

Human Rights Complaint for Transsexuals as Medical Patients

Introduction.....	1
Problems Faced by Transsexuals in Daily Living.....	2
Intersectional Issues	5
Quality of Healthcare Allocation Between Competing requests For Treatment	6
Who Are The People in English Speaking Countries Who Can Care for Trans?	9
Why Appropriate Trans Healthcare Needs to Be Discussed in Public	10
Selection of Helpful Trans Healthcare Providers.....	10
Conclusions.....	11
Appendix A Compassion and Human Understanding	14
A.1 Compassion for transsexuals Examples of being able to see humanity in transsexuals	15
A.2 How Norman Spack transformed the way we treat transgender children TheBostonPhoenix by copying The Netherlands	18
A.3 The Impact of Stigma on Transgender Identity Development and Mental Health Walter Bockting Columbia University ..	25
A.4 How Living With and Loving Bruce Jenner (now Caitlin Jenner) Changed My Life Forever by Linda Thompson	27
Appendix B English Culture as a barrier to Trans Healthcare	36
B.1 Medical culture barriers to giving transsexuals competent medical care	37
B.2 English Culture Barriers to Provision of Healthcare for Trans Chapter 8 Simona Giordano	39
B.3 English Culture Barriers to Government Funding of Healthcare for Trans Chapter 9 Simona Giordano.....	51
B.4 The Lancet - Insight - News - Is change possible?.....	61
B.5 The Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey (Youth'12).....	62
B.6 Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada:	63
B.7 Factors Impacting Transgender Patients' Discomfort with Their Family Physicians A Respondent-Driven Sampling Survey	64
Appendix D. Health Minister Dr. Jonathon Coleman's Nutty Comments About Funding For GRS	74
Appendix E. The waiting game waiting for GRS in NZ By Jacqui Stanford 2012	77
Appendix F. Examples of Possible Trans Suicides ignored by Healthcare Planners in NZ and Australia	79

Introduction

Human rights complaints are based on defining a subgroup of the societal population and showing that all of these people receive poorer treatment than other members of the society, in a way that undermines their equal opportunity and participation in the society, in a manner that is readily and practically able to be improved.

In this complaint, the defined group of people are “transsexuals”, who have a medical condition in which their brain developed prenatally in the manner typical of the opposite sex of foetus. This condition is presently not able to be economically and reliably diagnosed by existing medical tests. It is diagnosed indirectly by observing the social distresses and usually sexual behaviour dysfunctions that result. Treatment cannot redevelop the brain in accordance with the biological sex, so the only possible treatments are to alter the body to match the existing brain development.

To share the available medical treatment budget among a diverse group of patients, with problems of varying severities and costs to treat, treatments are funded from the lowest cost, up to some \$/QALY level, at which the health budget is nearly fully consumed. At present, the clearing cost/value level is about \$20,000 to \$30,000 per Quality Adjusted Life Year (QALY). Some treatments are funded at a cost of \$600,000 per QALY. These are approved individually on special application by medical specialists. By contrast many basic transsexual medical treatments are routinely refused at cost levels of \$5,000 to \$16,000 per QALY. As the number of transsexuals is quite small, providing transsexual treatments would have only a small impact onto

Human Rights Complaint 034 to UN

provision of other medical treatments for other patients. Certainly much less impact than the routine denial of treatment has had on transsexuals.

Interestingly, by applying uniform equitable healthcare allocation by \$/QALY, leads to the same treatment protocol and funding formula that The Netherlands, Germany, France, Norway, Sweden, Denmark have been following for 40 years now. State of California has now been following that protocol for about 10 years now. NZ, Australia, UK and most of USA have been following much more restricted treatment and funding protocols, by refusing to follow equitable allocation procedures. This is an example of human compassion eventually overcoming prejudicial cruelty, inhumanity and religious intolerance.

In addition to the treatments provided within a financial year, the denial of transsexual treatments for prior time periods, up to this year, has resulted in an unmet need that is many times the current new demand per year. In addition, older transsexuals have suffered considerable disadvantage by treatment withholding from earlier years and from the loss of opportunities due to being forced to self fund their own medical treatments. This historical overhang is inequitable, due to the many intersectional disadvantages that have accumulated. Presently, ADHB is diverting conversation away from any form of compensation for past treatment denial and consequential costs onto already disadvantaged transsexuals. This reflects their general treatment denial attitude and this does need to be addressed. It is difficult to say what compensation should be paid with respect to transsexuals who suicided before ADHB's attitude to transsexuals has improved.

Although mostly medical treatments are seen as a private matter, many christian churches need to take a large, abusive interest in transsexual's private medical treatments. They heap public abuse and humiliation onto them, for the benefit of someone's soul. This discourages doctors from offering medical treatments to transsexuals and Governments from funding medical care for transsexuals. People who understand positive mental health and child protection, characterise these abusive behaviours as bullying from a position of privilege. It is notable that children in these christian churches have markedly higher suicide rates, especially those that are LGBT, in particular the transsexual children. A few of these churches are softening their stance, as they start to understand the damage it puts onto their children, in particular as suicide.

Unusual for most medical conditions, transsexuality is notable in English speaking cultures, for the high degree of stigmatising that has resulted from "christian" churches unusually narrow and arbitrarily restricted views of human sexuality. These cultures present transsexuality as a perversion of their religion and greatly increase the social problems faced in daily life by transsexuals.

Thus probably more than 50% of the transsexual suicide rate is driven by antifactual beliefs in wider society, that impact very prejudicially and destructively into transsexual's lives. (The other less than 50% of suicides is driven by the internal discomfit due to mismatched body and social/sexual instincts.)

Transsexuals have been said to be a group with a small, low-cost medical problem and a huge social problem.

No other patient group faces such cultural barriers to getting general and specific medical care and access to general public social services. (Intersex or Disorders of Sexual Development patients generally face similar problems to transsexuals, but the degree of stigma and public humiliation by christian churches is not as severe and destructive. Their numbers are about 100 times higher and likewise, should not be ignored.)

Problems Faced by Transsexuals in Daily Living

In theory at least, positive public health public information campaigns could result in dramatic improvements, ie reductions in antifactual stigma against transsexuals. However, NZ health authorities and funders refuse to consider any such campaigns and NZ trained medical practitioners are among the most stigmatising members of NZ society, both in their public behaviours and their private treatment of transsexuals at medical consultations.

As a result, transsexuals go to great lengths to identify helpful and knowledgeable medical practitioners and also tend to avoid medical practitioners unless in dire need. No other patient group faces such pervasive and aggressive antifactual barriers to accessing everyday medical treatment. Unfortunately, transsexuals are not even benefiting from public health analyses to target

Human Rights Complaint 034 to UN

resources to improving treatment available for them. Despite the poor services available from the medical profession, there has only been one research project in NZ, that covered transsexuals and that was incidental to addressing wider LGBT issues. The end result had only poor coverage of transsexuals. By comparison, there are hundreds of public health studies covering blood pressure lowering and all sorts of physical and mental health issues.

Transsexual as a name perhaps implies a racial group or a group who have chosen for some reason to belong. On the contrary, human gender is largely determined by the differentiation of the brain, 4 months before birth. In 99.9% of people, this will follow the differentiation of the genital and reproductive organs at 6 months or so before birth. For the remaining 0.01% to 0.1%, Houston we have a problem! Untreated, this medical condition leads to discomfort that takes some 10% to 20% of untreated transsexuals to suicide in their lifetime. The only other common conditions that lead to so much life discomfort are schizophrenia and Borderline Personality Disorder. These too are physical conditions within the brain and neither has any cure. Palliative type treatments are all that is available from medicine, there are no cures. For a small medical issue, transsexuals have great social difficulties in english speaking "christian" western countries. Cultures with a more open view of sexuality and gender pose much less stigma for trans people, though the suicide rate is still fairly high compared to the wider population.

When a person's sexuality doesn't match their biological sex, they are in a poor situation to enjoy their own sexuality. This has biological effects on welfare, as well as the perhaps obvious social impacts onto intimate relationship formation. There is a surprisingly large set of effects on welfare, for perhaps under 10,000 brain cells directly out of common adjustment. The consequential brain development affects many areas of the brain, from cognition, to auditory and visual processing, to social values that underly behaviour, to sexual instincts. All of these impact on everyday human development through all of childhood, in a manner difficult to appreciate without a substantial amount of contact with transsexuals. The teaching profession has developed better transsexuality understanding, due to their compassion for students, care about student's suicide rates and spending more time with students.

As most doctors see patients for less than 15 minute consultations, medical practitioners are very poorly placed to understand these issues and only a tiny minority ever gain an understanding that leads to being helpful to transsexuals, through their own experience in daily practice.

Present NZ medical training ignores all of these issues and presents transsexuals to medical students as Obsessive Compulsives, delusionals and unhelpable mental health patients. This negative information training results unsurprisingly in huge barriers to medical practitioners offering helpful, compassionate medical services to transsexuals. It also leads to a self-protective degree of fear of doctors among transsexuals.

Medical professionals self-assessment of their ability to offer compassionate help to transsexuals has little or no relevance to transsexuals' assessment of practitioner's ability to help them. The cultural and antifactual barriers in the heads of medical practitioners are impossible to self-observe, without considerable time spent on reflection. As a result, most practitioners will never be able to self-develop skills to help transsexuals in daily practice. The internal cultural barriers that they cannot self-observe are just too great, for the little effort that they are willing to put in. Most practitioners have great confidence in their medical training and skills and the prejudices inbuilt into NZ medical training is a massive barrier to listening openly to transsexuals. (It is also true to say that there is quite a bit of self-delusion among transsexuals. The combination of all of these factors does result in a situation where it is extremely difficult to develop and apply helpful and constructive treatment protocols.) When a medical practitioner's treatment is unsatisfactory to the transsexual, typically they don't complain, just move on and try to find a more effective doctor. Examples are doctor's stigma triggering suicidal reactions in a transsexual patient. Afterwards, the dangerous doctor has no idea of why the patient never returned. Even if they were told, they wouldn't understand, it was just the patient's problem anyway..... This happens across NZ each day.

Due to the barriers described above, it is essential that transsexual patients have informed choice of medical service provider, to prevent abusive capture of benefits by incompetent doctors. Ideally trans should operate their own medical board, choose employees and manage it to protect their interests from medical practitioners.

Human Rights Complaint 034 to UN

Although the public see crossdressing as the only important issue relating to transsexuals in society and one needing condemnation and public humiliation (but in a loving and compassionate manner), transsexuals live under the following disadvantages:

1. transphobia results in extreme difficulty in gaining and holding employment
2. transphobia results in great difficulty in obtaining everyday medical advice and care
3. transphobia results in social non-inclusion in most environments, limiting access to development opportunities
4. transphobia results in extreme stresses, that distract from learning opportunities and restrict access to learning environments. Then there is often a follow on effect, that transsexuals cannot self-fund their medical care.
5. transphobia restricts access to intimate and supportive social relationships
6. transphobia restricts access to intimate sexual relationships, which restricts development
7. poor access to employment restricts transsexuals ability to self-fund their medical treatment. (As a result, the poor public funding of transsexual's healthcare results in much poorer access to medical treatment, than might result if for example professional's were not offered Government funded medical care, as most transsexuals have very little disposable income to fund their own medical care from. Most commonly when transsexuals can self-fund, their medical care is funded privately by family. This is then used as proof that the Government doesn't need to fund transsexual's healthcare! Much more commonly, they are left without satisfactory access to medical care, either by lack of funds or by inability to get to a non-prejudiced medical practitioner. Having spent their money on their own medical treatment, they are too often unable to afford eye, teeth or ear treatments, or ongoing education. They are then very poorly placed in the job market.)
8. Stigma results in extreme reluctance to seek any help and great fear of opening up to be able to accept help.
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9. "wrong" internal instincts restricts sexual performance, which restricts social and sexual development or relationships.
10. Internal stresses from lack of trans appropriate care, distracts from ability to learn.

It is important to note that items 1 to 8 result from anti-factual knowledge in society or medical practitioners and items 9 and 10 are consequential to the medical issues of transsexuality. Accordingly, transsexuals could benefit hugely from public health research and from positive public information. However, the NZ medical establishment will have nothing to do with either! Such campaigns are not just for the comfort of transsexuals, but to allow equal access to social functioning and for removal of social stressors towards suicide. Such campaigns would also make sure that transsexuals hidden in society were informed of help available, where presently such help is more like a guarded secret! As a direct result of the refusal of Health Department and Hospital Boards to fund positive public information about the availability of existing services, transsexuals are still choosing suicide completely needlessly.

Item 10 results from poor public provision of transsexual healthcare, although the teaching profession are doing their best to cover for the lack of positive performance by medical professionals.

This refusal to address positive public information is so aggressively prejudiced, that ADHB will fund Parkinson's treatments at over \$500,000 per Quality Adjusted Life Year, but not transsexuals healthcare at under \$5,000 per QALY or public information provision. And they are thinking that they are doing a great job!

If equity were to be taken into account, then transsexuals shouldn't be "charged" for positive public health information programmes, as they would be addressing wrong information in society. If anything, these costs should be born by "christian" leaders and incompetent medical planners.

Human Rights Complaint 034 to UN

The National Party policy that transsexual healthcare shouldn't be funded publicly can be seen as driving down the public cost of prostitution, by leaving that as the only avenue by which many transsexuals could ever hope to fund their own healthcare. This could be seen as a form of sexual slavery. It does illustrate the lengths that most transsexuals are "willing" to go to, to access effective and complete medical care. This does support that GRS is seen as valuable and essential by many transsexuals and they show that by their private paying of these costs, despite their generally very low disposable incomes. Although the cost of GRS surgery is fairly low when judged from the perspective of a Minister of Health, or a medical practitioner, it is fairly high cost for most transsexual's pockets. (About 60% of NZ transsexuals are unemployed.???? 80% in USA???) Having paid for their medical treatment privately, many are then left with extreme difficulty to pay for ongoing education. Again, this then impacts on access to employment. This is another example of the intersectional effect, where problems more than add.

Although the Minister of Health publicly presents GRS surgery as "high cost", in the same way that orthopaedic surgery gives the patient benefits that last for many years, the same is true for GRS for transsexuals. Orthopaedic surgery is provided routinely, without public embarrassment, at the same cost level as GRS, without calling it "high cost treatment".

Intersectional Issues

In the same way that most marginalized groups suffer additional problems due to the intersectional effect (that the addition of two problems causes more difficulties than just the addition of the effects of each difficulty taken separately).

In addition, transsexuals appear to have slightly higher rates of many other disadvantages, than in the general population. These range from deafness, multiple sclerosis, to autism, to other mental health issues as well. The combination effects can be quite severe in a subgroup of transsexuals. In many cases, family carry this load and also help fund access to medical treatments, in a manner which is not so common in families of other patient groups.

Due to the slightly higher rates of other disadvantages, the rates of multiple disadvantages are much higher than in the general population. This paper has not included intersectional effects into the numerical \$/QALY analyses. This omission leads to serious underestimation of the inequality that the aggressively prejudicial access to medical treatment causes. These issues do need to be carefully and non-prejudicially considered in the individual treatment planning process.

Transsexuals paying privately for their medical treatment, are then often seriously disadvantaged in being able to afford education or treatment for other disabilities – such as deafness. These intersectional effects are severe and in the long run, have massive negative impacts on the life of many transsexuals. These intersectional effects are difficult to appreciate, to professionals earning many hundreds of thousands of dollars per year. To understand them, it is necessary to learn quite a lot about the transsexual's life. It isn't comfortable for either party, to make such detailed enquiries about ongoing disadvantage, which is usually socially presented as bad management by the individual, rather than as a normal consequence of refusal to Government fund basic medical care for transsexuals. This is why most medical practitioners have so little practical understanding of trans' lives.

I see NZ trans treatment as being based on UK, Australia and USA, which are among the worst in the developed world, except soviet Russia. NZ appears to be following the UK Charing Cross model of delayed, dithering, diffident service. This unconfident medical service, results in much increased cost of treatment, which further disadvantages transsexuals.

We need to be learning from the countries that have been actively and effortlessly providing good quality trans healthcare through the last 40 years, such as The Netherlands, Germany, France, Belgium, Norway, Denmark and Sweden. Dr. Harry Benjamin published his book setting out hormonal, psychotherapy and surgery for transsexual treatment in 1953, now 63 years ago. English speaking countries have erratically made progress and faltered disastrously in following on from that lead.

Intersectional Issues Over More Than 1 Year

The accumulation of disadvantages has effects lasting far longer than 1 year. By being forced to pay privately for much of their medical care, trans are usually left poorly placed to afford sight, hearing and general medical care. Similarly, they are often seriously disadvantaged for being able to pay for ongoing tertiary education. Their small disposable incomes results in accumulating disadvantage.

Human Rights Complaint 034 to UN

In addition to social disadvantages, transsexuals are typically so economically disadvantaged, that they are unable to purchase or maintain their own home. This then leads to further security, social and economic disadvantages.

These are the reasons that ADHB must be forced to fully compensate for treatment refusal in earlier years and the consequential costs that result from iniquitous refusal of funded healthcare in earlier years. It is completely unethical that medical staff earning many hundreds of thousands of dollars per year, wish to leave this accumulated disadvantage on the shoulders of generally the poorest and most socially disadvantaged members of our community, that have resulted from their earlier failure to perform competently.

Quality of Healthcare Allocation Between Competing requests For Treatment

I am aware of the extent to which healthcare is allocated to deserving victims and vulnerable people. ADHB members are voted in on a first past the post voting system. Such systems are responsive to social groups over about 10% and have negligible response to groups like trans, in the 0.01% to 2%, depending on how trans is defined. Whether or not anyone has an interest in offering healthcare to trans, such voting processes reinforce large, visible groups and ignore small, marginalised groups.

Allocation of healthcare on the basis of cost effectiveness at achieving increases in Disability Adjusted Life Years provides a method aimed as far as possible at achieving allocation on the basis of individual "comparable need and value". Quality of Life (QoL) can be taken into account in such evaluations, as well as the physical aspects of living. (DALY WHO Common values in assessing health outcomes from disease and injury: disability weights measurement study for the Global Burden of Disease Study 2010 and Appendix 2013) This procedure provides a formal analysis, which reduces the effect of prejudices on intuitive methods of decision making. This then provides much greater protection for unpopular or marginalized groups of patients.

Where Quality of Life (QoL) is ignored, then trans are easily ignored, as we do now. \$/QALY analysis has the effect of lifting priority to children's care, as they will benefit for many more years, than for example elderly patients nearer to death. Children helped with deafness, can then learn and socialise more effectively, through their entire development. Similar arguments would apply for trans, if they could be seen as human, in the english speaking world.

To share the available medical treatment budget among a diverse group of patients, with problems of varying severities and costs to treat, treatments are funded from the lowest cost, up to some \$/QALY level, at which the health budget is nearly fully consumed. At present, the clearing cost/value level is about \$20,000 to \$30,000 per Quality Adjusted Life Year (QALY). Some treatments are funded at a cost of \$600,000 per QALY. These are approved individually on special application by medical specialists. By contrast many basic transsexual medical treatments are routinely refused at cost levels of \$5,000 to \$16,000 per QALY. As the number of transsexuals is quite small, providing transsexual treatments would have only a small impact onto provision of other medical treatments for other patients. Certainly much less impact than the routine denial of treatment has had on transsexuals.

Interestingly, by applying uniform equitable healthcare allocation by \$/QALY, leads to the same treatment protocol and funding formula that The Netherlands, Germany, France, Norway, Sweden, Denmark have been following for 40 years now.

NZ theoretically provides access to GRS surgery through a High Cost Treatment pool, despite GRS officially being considered "cosmetic" and "nutty"! The definition of GRS as cosmetic, was made in the report: NZ Transgender Reassignment Surgery Health Technology Assessment Report by Peter Day Otago University NZ Feb 2002

(http://nzhta.chmeds.ac.nz/publications/trans_gender.pdf) . This report was setup to fail to justify GRS as being health economically justified medical treatment by the following sleights of hand:

As an evidence based report, it considered only studies based on Randomised Controlled Trials.

When no RCTs are found, normal professional practice in evaluation research is to look at the next lower standards of evidence. (This is akin to use of circumstantial evidence, when there is no available direct evidence in criminal trials.) Lower standards of evidence are available in hundreds of studies spanning 50 years of research, but these were ignored completely. This is like Commander Horatio Nelson putting his known blind eye to his telescope, to avoid seeing what it was his duty to see.

Human Rights Complaint 034 to UN

Similarly, treatment protocols from Europe, UK, USA, Australia and Canada were completely ignored too. Comments above apply again here. This is like Commander Horatio Nelson putting his known blind eye to his telescope, to avoid seeing what it was his duty to see.

In preparing NZ Transgender Reassignment Surgery Health Technology Assessment Report, there was no communication with affected patient groups. This suggests that trans inexperienced medical opinion of welfare was preferred over any listening to affected patients or listening to both. This approach smacks of gross medical arrogance, total absence of empathy and scant professional care. The health economic analysis ignored the benefits to the patients, which is really the reason for performing the analysis! Benefits for doctors appears more important than actually delivering benefits to stigmatised marginalized patients.

Curiously, GRS surgery is not actually high cost, as the utility spans many years. Therefore access should not be arbitrarily and cruelly restricted by this funding politics trick. Most of the actual high cost treatments provide benefit only for a fairly short time. Thus the \$ / QALY disparity between healthcare for trans and for real people, is a ratio of 20:1 or more against trans.

That level of analysis does not consider equity of access to healthcare. When the disposable incomes of patient groups is compared to other patient groups, then the inequity is greater still, due to the high levels of unemployment among trans. GRS at a cost of MtF \$25,000 or FtM at a cost of \$50,000 is routinely refused (period of delivering value 10 to 50 years and Disability factor 0.15 or more), whereas Parkinson's Disease treatments costing \$60,000 per year are routinely approved (period of delivering value 1 year per year of treatment and Disability factor 0.1). If patient disposable incomes were considered, the disparity is much greater still.

MtF GNRH and operated at age 20 without GRS \$/QALY = 5,667 now routinely approved by ADHB

MtF operated at age 20 with GRS \$/QALY = 6,286 not approved by ADHB

MtF operated at age 50 with GRS \$/QALY = 16,250 not approved by ADHB

Statins for blood pressure = \$/QALY = 20,000 to \$30,000 routinely approved by ADHB

Parkinson's Disease apomorphine treatment \$50,000 per year of treatment Disability Factor=0.1 \$/QALY= \$500,000 routinely approved by ADHB

The disparity of trans healthcare funding decisions can be clearly seen in the figure above.

The table above lists MtF transsexual treatments only, due to time limitations for preparation of this document. The matching FtM data would be fairly similar, in any case would come to the same conclusions that FtM are being denied treatment, that is health/economic justified.

The figures above have not included the advantages of suicide reduction, due to time to prepare. When that issue is included, then full European transsexual treatment, including GRS funded, is shown to be fully and unambiguously health/economic justified.

Provision of timely trans healthcare is critical to obtaining best life outcomes for trans children. Delaying treatment until after puberty, guarantees trans children stigmatising wrong puberty body development outcomes. This significantly reduces QoL for the rest of the patient's life. Trans outcomes at Charing Cross Hospital in London UK, clearly show the disadvantages of delayed treatment, for trans who are unable to self-fund their trans treatment from private suppliers. This also demonstrates the disadvantage resulting from preventing informed client choice over providers. Charing Cross delays GRS access to provide better legal protection for doctors from being sued by patients. This is despite European experience showing that there are very few such suits anyway (a few in USA only). The consequences severely damage the patients whole life, in terms of social ease and being able to enjoy their own sexuality, something which the doctors can do without any problems at all for themselves. The benefits of appropriate treatment for patients are being substantially ignored. They can't and won't see across the English Channel.

Human Rights Complaint 034 to UN

I understand that ADHB now offers some limited treatment for trans under 25 years. Although a staff member claimed that they follow the Amsterdam Protocol, the Amsterdam Protocol includes not financially restricted public funding of GRS, which is not funded for the vast majority of trans patients in NZ. Thus the claims of treatment were partially true and significantly misleadingly untrue also. Provision of misleading information to patients and the public, is just a form of unsatisfactory palliative care, substituting for professional care. This is a result of the blanket refusal by ADHB to fund treatment to trans equitably. Given that trans are among the most financially disadvantaged patient groups in NZ, the expectation that they should self fund their own treatment is unrealistic. Some are helped by families, some are pressured into prostitution and most have no opportunity to access GRS surgery. (The use of suicidal pressure to force trans into prostitution to fund healthcare treatment might be thought of as Government enslavement into prostitution?) By keeping this treatment relatively secret from the public, many trans children are being denied access to appropriate medical care, as their parents and many teachers don't know that such treatment is available in NZ!

Suicide conveniently takes away many untreated trans, estimated 10% to 20% through our lifetimes. Not all indicate trans issues in suicide notes, so it is difficult to gauge the contribution of trans to NZ's suicide statistics. Trans health is not measured or monitored in a way that professional management of welfare would be possible. This is a major cause of the deliberate failure to provide appropriate healthcare. This puts trans patients outside of the public health initiatives that are slowly and surely improving outcomes for all other patient groups.

I do understand that the trans condition is outside most people's daily experience of life. We don't meet most people's "normal logical expectations". Accordingly, trans are easily dismissed as not worthy of receiving public funds, that would be better spent on maternity or paediatrics, groups who haven't brought their affliction onto themselves. Similarly, why would anyone choose to develop lung cancer. There is more personal choice if they were a smoker, than for trans where their fate is sealed 4 months before birth. My lack of understanding of what breast cancer is really like, doesn't stop breast cancer patients from receiving appropriate treatment.

Use of the idea of "normal logical expectations" is just another indicator of trans-ignorant christian bigotry, which is too common in english speaking medical practitioners. Trans hate entering medical spaces, as we know how distasteful we are to most medical practitioners. This distaste and fear, cause unnecessary hazard to the quality and cost of the resulting healthcare that we receive. This just adds to our wider social and health problems. ADHB are more part of the problem, than part of the solution. There is no sign of this changing during the working lives of presently qualified NZ medical practitioners. The very slow spread of trans understanding among NZ medical practitioners, chills me to my unauthentic plastic bones.

Transphobia is just an echo of the public health attitudes that left mental health services so severely underfunded for decades. Even when Government allocated additional funds, after publicity surrounding psychiatric murders, the funding was diverted into overheads and management. Effectively this diverted the value to sexy areas, such as maternity and paediatrics. This went on until the Government used forensic accounting to ring fence it's financial allocations, to ensure that funding did go to provision of mental health services for patients. Like mental health patients, transsexuals are not much listened to by the public, so are in a difficult position to advocate for improved healthcare for ourselves.

Health Minister Dr. Jonathon Coleman's consideration of the funding of GRS surgery for trans people, appears to be based only on his personal emotions, intuition and political savvy. (See appendix D)

The following article shows that Dr. Jonathon Coleman's decision about the adequacy of trans healthcare in NZ was intuitive and emotional, not based on cost per health improvement in Quality Adjusted Life Years (QALY). This approach, by a professional politician, appears to be more based on perceived voter support and his own benefit, than equitable access to healthcare for all members of NZ society.

The QALY (or Disability Adjusted Life Year) approach was developed by Harvard University public health specialists, for prioritising healthcare decisions, to ensure fairness of access to medical treatments, even for marginalized groups within society. The method is now being supported by World Health Organisation, for informing health allocation decisions in countries all around the world. It would appear that Dr. Jonathon Coleman, Minister of Health, hasn't even heard about QALY calculations and equity of access to medical treatments. This should bring into question his fitness for his job as Health Minister, as one of his main functions is ensuring equitable access to healthcare for all NZers. Similarly, there has been no comment by medical practitioners about Dr. Jonathon Coleman's

competence either as a doctor or as Minister of Health. Should that call into question NZ doctors commitment to equitable access to healthcare?

The \$/QALY analysis shows that ADHB has routinely, for the last 30 years, diverted funds that should have been spent on transsexual's healthcare, onto other patient groups. Operating under a fixed funding limit, it can only fund transsexual healthcare, by diverting these funds back to equitable distribution, as indicated by \$/QALY analysis. This will cause very slight negative impacts onto large numbers of patients, for example for access to blood pressure lowering medications and the like (ie barely noticeable).

Although GRS is publicly presented as an elective surgery, that is very expensive, it is an essential part of allowing transsexuals to enjoy their own sexuality in a natural way (in the way that non-transsexuals have been able to enjoy their own sexuality since puberty). The actual cost is midway among many orthopaedic surgeries, that are routinely carried out and routinely approved without undue dramatisation. In any case, most people do place a fairly high value on being able to enjoy their own sexuality. This shows up in damages payouts after industrial accidents, where sexual function was impaired or destroyed. It shows up in the willingness of USA military spending up to \$400,000 for reconstructive surgeries for injured soldiers, who have enjoyed their own heterosexuality since puberty. But the National Party of NZ doesn't want to fund GRS for transsexuals in the range \$25,000 to \$50,000, for people who have never been able to enjoy their own sexuality naturally and it also wants to delay any spending using decades long waiting lists until patients are so old, that they have probably forgotten what sexuality was.

Trans responses to our internal conditions and to society's treatment of us – easily reinforces the view that we have chosen to be insane. At least in the minds of darkly prejudiced, uninterested, uncaring trans-ignorant christian observers.

J. Michael Bailey, a USA sexology psychology professor suggested that MtF trans were particularly suited to work as prostitutes, on the basis of his poorly chosen sample interview group and his poor understanding of what they said to him. This raised large objections from a wide range of trans. The controversy doubtless aided the sales of his books and constituted an unmanaged conflict of interest. In any case, although prostitution has now been legalised in NZ, this does not constitute proper ethical justification for denying proper medical treatments to trans and leaving them to self-fund their treatments through prostitution.

Who Are The People in English Speaking Countries Who Can Care for Trans?

The most positive attitudes to understanding trans and treating trans as humans, comes from educational professions and non-english speaking medical practitioners in continental Europe. In other words, almost all english speaking medical practitioners have never got past christian ignorance and bigotry. This is like "the operation was a success, but the patient died" attitudes.

The people who do care constructively for trans, do so because they can see some humanity in trans, not because treating them pays extremely well or gains public prestige. There are more books in the Epsom Teacher's College Library about trans and trans care, than in the Grafton Medical School Library. More critically, the Epsom Teachers College books are much more thumbed, showing more use and interest. The actions in the professional schools, largely controls and limits the performance of the respective professions for the next 4 decades. This suggests very little interest in trans by practicing NZ trained medical practitioners and constructive supportive interest by teachers.

I am aware that even having some customer contact doctors with an interest in trans cannot in the long run provide continuity of competent care, when set against management with transphobic prejudices and lack of any interest. I have seen the same dynamic in CYFs / Social Welfare, where competent staff were unempowered by careless, destructive management and Government policies towards clients. In the long run, organisational malice always rules over staff with skills and heart. Staff should not be put in the situation where serving customers comes at the price of risking their own career.

Trans experience with medical practitioners in NZ shows that the practitioners who can listen and respond appropriately, are mainly overseas trained or NZ trained but grew up in a non-english speaking culture eg Indian culture born in NZ and are mainly women. The issues are:

Absence of christian sexual prejudices.

Suitable training materials for assisting practitioners to deal with LGBT patients are available at no cost for download, from the AMA on the internet. Yet the T of LGBT awareness does not form part of the present GP training in NZ, nor part of continuing education of GPs in NZ. The NZ medical profession is dangerously behind the leaders and the hazards fall not onto doctors, but onto patients. Although endocrinologists attend junket Symposiums by other english speaking doctors, they avoid listening to the doctors who are leading trans healthcare, the Dutch, German, French, Belgians, who publish in English but aren't really listened to!

Satisfactory trans healthcare can only be provided by people with some understanding of what is going on in the condition, which does take some degree of interest. At present, there is almost certainly a large, suppressed, unmet need, so that if a new service was brought into action, it would need to serve a rapidly increasing and then reducing again demand. Government organisations are poor at serving difficult to predict demand curves.

Why Appropriate Trans Healthcare Needs to Be Discussed in Public

I have seen teachers talk in public about the impacts of stigma on trans and encourage people to stop scapegoating and bullying.

I have never seen a NZ trained health practitioner present medically correct information to the public, that might reduce stigma on trans and use their public credibility to support trans in any way. You don't want any risk at all, to your own social position.

Both Ban Ki Moon and USA President Barack Obama have spoken in public without embarrassment, supporting that trans people shouldn't be discriminated against and humiliated for being. The ADHB has practically never spoken publicly about treatment of trans by the public or by doctors.

ADHB doesn't proactively inform the public about trans treatments that they sometimes offer. If individual members of the public are left unaware of treatments available, then surely it is unreasonable to expect them to seek and ask for treatment. This failure to make information available to the NZ public is really a discriminatory form of treatment rationing. It is known that suicide is a fairly likely outcome of non-treatment.

Three years ago a close friend suicided without actionable warning. When I started facing my transsexuality and learned more, I realised that he was probably trans too. Failure to educate the public leads directly to preventable deaths and doubtless is continuing to cause preventable deaths. (See Appendix F. Examples of Possible Trans Suicides ignored by Healthcare Planners in NZ and Australia. Suicides with no prior warning are almost certainly due to extreme stigma, preventing help seeking. Although this could be LGB, usually only T suffer so much stigma as to suicide with no warning.) All of this is due to the unprofessional attitudes of ADHB managers, in refusing to perform a \$/QALY analysis of their refusal to offer a complete transsexual healthcare service.

It is exactly for the purpose of exposing the inequity of emotional decisions about relative funding of health treatments, that World Health Organisation encourage developing countries to check the equity of their health funding decisions. Yet in NZ our health funding decisionmakers are refusing to carry out a \$/QALY analysis and the inequity for transsexuals continues.

Most of the public consciousness about trans issues comes from misinformation in cheap media exploitation of sensationalised trans stories, cheap USA exploitation drama, USA pornography and christian trans-ignorant proselytising scapegoating. Together, the misinformation is formidable, but not a single NZ medical practitioner has seen fit to open their mouth publicly to set the record straight on the medical basis of transsexuality. This is why I don't see the NZ medical profession as being qualified to take any part in trans healthcare, for the foreseeable future eg the rest of this century.

Selection of Helpful Trans Healthcare Providers

Unlike most patient groups, trans people find considerable difficulty to find healthcare providers who are willing and have to values and skills to help them. Unless the doctor has a reasonable understanding of what life is like for trans, internally and socially, they cannot assist in recommending treatments and providing support. The doctor's decisions may serve their own culture, rather than actually help the trans person, in the situation that they are in.

Human Rights Complaint 034 to UN

Most NZ trained doctors are self-opinionated, medically superior, arrogant, trans-ignorant and not interested in trans existence.

I am scared at the thought of asking for care from these people, when I know that interested providers easily do so much better. I am scared to be in hospitals where doctors and managers have only poor understanding of trans' lives and treatment options. Trans healthcare works well only when trans can make informed choices about their care and provider and funding systems support and enable informed customer choice. This is not served by Government giving all funding for trans health treatment to local DHBs, who then don't serve transsexuals and the funding is diverted to other patient groups.

This ongoing neglect has built up a large unmet need, which is presently being ignored by the DHBs. There is no initiative to make up for the past damage done by medical ignorance and neglect, yet the intersectional effects of this neglect are seriously negatively impacting the lives of many transsexuals. The most obvious example is where past self funding of GRS is not preventing access to ongoing educational needs. The damage per patient is typically \$25,000, plus time value of money and opportunity cost. The absolute unwillingness of DHB to address this issue is another reason why trans healthcare needs to be provided outside of the existing DHB structure.

Trans health care is not rocket science. I have seen hormone prescribing summarised on a single A4 page and well covered in 25 pages. I would prefer that hormone prescription was handed over for self prescription and/or prescription by interested teachers. These are people who have their heart in providing care, rather than financial returns and social prestige. Normal safety guidelines don't need to be applied for trans people and shouldn't be applied, as the remaining risks are greater than for most patients. Most doctors want to dither around on little relevant safety worries, as a means of avoiding commercial risks to themselves, at the cost of delaying and reducing quality of care to the patient, though still charging for their service. Trans self medication has a long and fairly successful history, particularly when we have unrestricted access to blood testing for management.

Mental health care for trans is presently most effectively supplied by trans for trans, on a financial shoestring, completely independent of ADHB, thank god. If the medical establishment want to take control of such services, I would ask that they prove that their offering is in fact safe and constructive for trans, before demolishing what trans have already built up and got into working condition. Service provision should be on an equal financial basis, so that any ADHB offered service, competing against trans for trans services, could succeed or fail on the quality of service actually provided. This would avoid unnecessarily jeopardising the existing trans for trans services.

I can see an argument for allowing trans to receive medical care alongside other patients, but this argument would only stand if the medical profession could eventually rid itself of trans-ignorance and christian transphobia. Until then, perhaps around 2060 if forward progress was to start today, it is better to provide trans healthcare completely independently of ADHB.

I know that the NZ medical establishment is unskilled at learning from the non-english speaking world. I have seen the same in other areas of medicine. The Dutch lead in the care of trans children and adolescents, as well as adults. Their research is in the top league, along with Germany. Although anglophones may use "german" as an epithet for ignorance, greedy violence and christians doing murder, the Germans are also among the world leaders for trans research. It is not as though these countries are secretive about their trans research, most of it is freely available in english! The secret is the active ignorance within the NZ medical profession. The only "secret" that the german and dutch medical researchers have, is choosing to give human respect to their trans subjects' lives. Their research is then able to contribute to improving the QoL of trans people. These researchers into trans existence, have trans welfare in their Dutch and German hearts.

Conclusions

The \$/QALY calculations show that transsexuals are being routinely denied appropriate healthcare for their transsexual condition.

This refusal to provide care, is because ADHB treatment planners have simply ignored transsexuals as a marginalized group, lacking public support for their medical treatment.

Human Rights Complaint 034 to UN

The consequential costs of refusal to provide medical treatment, are unusually high for transsexuals, due to their poor economic position and their high rates of other disabilities. Both of these issues are in equity, thus the refusal to offer satisfactory treatment is a serious and ongoing breach of basic human rights.

The historical disadvantage to transsexuals of having paid privately for their medical treatment, in equity should be actively addressed by ADHB. The costs of past treatments, that should have been publicly provided, should be refunded by ADHB, to partially restore access to other medical treatments and education and restore equity.

Trans people should be able to receive publicly funded competent healthcare, to a standard as justified by QALY cost effectiveness, on an equal and equitable basis to other medical consumers.

Appendix A. Compassion and Human Understanding

A.1 Compassion for transsexuals Examples of being able to see humanity in transsexuals

A.2 How Norman Spack transformed the way we treat transgender children TheBostonPhoenix by copying The Netherlands

A.3 The Impact of Stigma on Transgender Identity Development and Mental Health Walter Bockting Columbia University

A.4 How Living With and Loving Bruce Jenner (now Caitlin Jenner) Changed My Life Forever by Linda Thompson



triptone:

Last night my little sister (5th grade) was making an e-mail account

She saw gender and went to click female when she noticed the "other" choice

She looked at me confused and I started to explain that some people don't think they fit in with strictly male or female

"Oh! You mean like transgender and stuff like that. I was freaked out for a second- I thought they meant robots."

Yet another example the kids are more open-minded than adults

Source: groovygranola

217,384 notes



Appendix B. English Culture as a barrier to Trans Healthcare

B.1 Medical culture barriers to giving transsexuals competent medical care

B.2 English Culture Barriers to Provision of Healthcare for Trans Chapter 8 Simona Giordano

B.3 English Culture Barriers to Government Funding of Healthcare for Trans Chapter 9 Simona Giordano

B.4 The Lancet - Insight - News - Is change possible?

B.5 The Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey (Youth'12)

B.6 Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada

B.7 Factors Impacting Transgender Patients' Discomfort with Their Family Physicians A Respondent-Driven Sampling Survey

Appendix C. Cost Per QALY calculations for Trans Healthcare

Appendix D. Free surgery bid "nutty" - Health Minister Dr. Jonathon Coleman

Appendix E. The waiting game waiting for GRS in NZ By Jacqui Stanford 2012

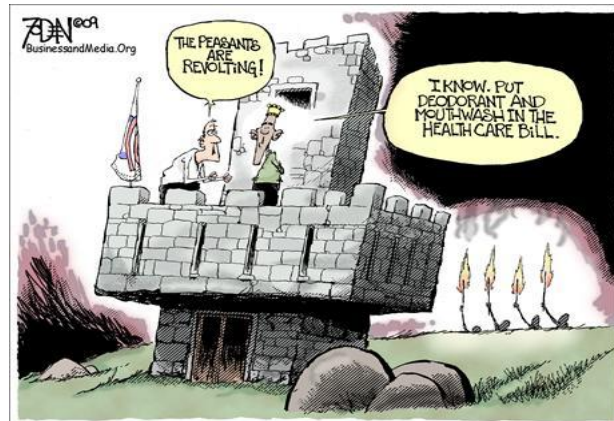
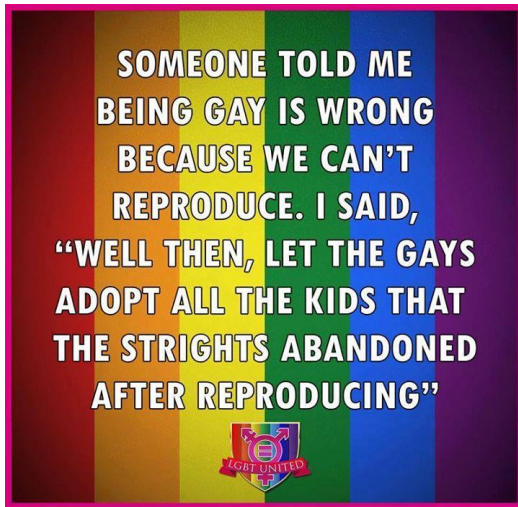
Appendix F. Examples of Trans Suicides ignored by Healthcare Planners in NZ and Australia

Appendix A Compassion and Human Understanding

Compassion for transsexuals Examples of being able to see humanity in transsexuals

How Norman Spack transformed the way we treat transgender children TheBostonPhoenix by copying The Netherlands

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from Principles of Transgender Medicine and Surgery

Foreword

In 1992, I saw my first gender dysphoric patient. My wife, clinical psychologist Randi Ettner, had phoned me early one November morning. She was concerned about a client who had arrived at her office with a high fever, facial pain, and headache. He was suffering from a sinus infection, but his family doctor had told him, "My religion prevents me from taking care of you." The client was taking cross-gender hormones.

I still shudder to think that in a metropolitan area as sophisticated as Chicago, basic medical care was largely unavailable to people with certain gender conditions, withheld by a profession purportedly committed to the Hippocratic Oath.

Many gender-variant individuals have come to avoid all contact with medical providers, fearing such stigmatizing interactions. Thus, many have not availed themselves of preventive health care services, such as recommended routine screenings.

On that day, I determined to learn everything I could about the treatment of gender-variant individuals and their medical needs. The waiting room of my family practice became an odd aggregate of pregnant women, pre-schoolers with runny noses, and transgendered people.

While my colleagues in the Harry Benjamin International Gender Dysphoria Association (HBIGDA) have been extremely generous in sharing knowledge about the protocol for hormonal reassignment and the effects of such use on every organ system in the body, it is my transgendered patients who have taught me the most. Over the years, I, in turn, have educated cardiologists, general surgeons, dermatologists, and other specialists when referring my patients to them. I have sought to create a network of health care providers who are knowledgeable and responsive to their medical needs.

How I wish this book had been available in 1992! It provides state-of-the-art information from internationally recognized experts to health care practitioners who encounter, occasionally or regularly, individuals with unique gender identities. I hope it will become required reading in every medical school throughout the world, and makes its way into the hands of every physician practicing medicine today.

It is fortunate that Randi Ettner recognized the need for this resource, and I am grateful to Eli Coleman for expanding and implementing her vision. I hope this book will be regarded as a medical milestone, and that patients will never again be denied the respectful and appropriate care to which they are entitled.

Frederic M. Ettner, MD

Medical Director, Chicago Gender Center;

Member, Board of Directors,

New Health Foundation Worldwide

by Simona Giordano

Foreword by John Harris

Simona Giordano has written a beautiful and complex book, a compassionate, humane, elegant, and poetic book, about vulnerable and often violated people. This is a book few could or would have written, but of which anyone would be proud.

Dr. Giordano is a philosopher by training and a poet in spirit, and in writing about the predicament, condition, feelings, and lives of transgender individuals she deploys not only considerable philosophical and analytical skills, but does justice to other literatures: psychological, sociological, legal, medical, and artistic. The book draws on sources in all these fields as illustrative of her text and as grist to the argument, enriching our understanding and sharpening our insight.

I cannot think of a book quite like this. It defies classification, and yet by the power of its argument, the imagination of its conception, and the wealth of apposite examples and illustrations, it compels attention and surely shapes our understanding for the better. And by this I mean to include better morally and better in the sense of compelling a more rounded and sympathetic appreciation of both the complexity of the issues and the depth of understanding of the human dimension of that too often seen as a medical issue or indeed simply an issue of misguided preference.

What Giordano has achieved is the capture and celebration of the beauty of people in sad and wretched circumstances, and the nobility, not of suffering (there is nothing noble about that, ignoble rather), but the nobility of the minorities, who are often forced into unnecessary suffering for no other reason than their powerlessness. It is this exploration of the nobility of transgender youth, who are often vulnerable and disadvantaged, and of the ways in which the painful necessity of exhibiting that nobility can be removed or mitigated which is the great strength and the overwhelming virtue of this book.

.....

Preface

For reasons that will become clearer in the course of this book, many transsexuals also end up in the street. Often discriminated against in their social life since childhood, disadvantaged in their employment, and some-times alienated from healthcare services, transgender people sometimes find acceptance amongst peers and work as prostitutes. This may allow them to raise money for the hormones that are needed for their adjustment or for privately paid surgery, especially if they are clandestine immigrants. This exposes them to a number of perils, ranging from healthcare problems (including emotional trauma) to abuse and violence. Sometimes people get entangled in the justice system, from which it is particularly difficult to escape. Common prejudice may suggest that everyone chooses their lifestyle, and if people opt for street life, so be it. But it cannot be claimed that these people choose risky lifestyles and willingly expose themselves to violence. Trans are often left without recourse, and "people without recourse are not free"². It is in one sense true that there is rather little desert in virtue, and rather little fault in error.

This book is inspired by compassion for a group whose condition is often surrounded by misunderstanding and prejudice, and by the wish to bring back the dignity that is often violated in these youths, to return a drop of the glow that such diversity brings to humankind.

.....

There is a second and equally important reason why I mix various styles in this book: philosophers who, like me, have specialised in healthcare ethics, often mature a tendency to write books aimed at healthcare professionals or at other healthcare philosophers. But perhaps there is nothing that healthcare professionals should know, that sufferers, including children, should not also know. Gender concerns us all: we are all either men or women or a part of gender minorities. Indeed, I will suggest that we are all somehow in between, and a discourse of who we are and why we are who we are is one that should be of interest to everyone.

from **Supporting Transgender & Gender Creative Youth**

Introduction

THE ERASURE OF CHILDHOOD GENDER-CREATIVITY

by KIMBERLEY ENS MANNING, ANNIE PULLEN SANSFACON, AND ELIZABETH J. MEYER

Why is dominant Canadian culture so ignorant as to the possibility of childhood gender-nonconformity? Why is it that health-care providers and teachers so often say, "But how can the statistics be that high? I have never met a transgender child." At issue here, we suggest, is a complex erasure of the lived realities of gender-nonconforming children. Just as the lives of transsexual and transgendered people have largely been rendered invisible in this country (Namaste, 2000, 2005), the gender-creative child can not exist in a world that does not recognize the possibility of a childhood inhabited outside of the gender binary. Yet as Bauer et al. (2009) note, invisibility on the social agenda can give rise to hyper visibility in daily life, with each individual instance treated as a "social emergency." In a sense the gender-creative child is unintelligible—unintelligible in speech, dress, comportment, social relations, and even in humanity. Indeed, transphobia remains so deep in North American society that to even put the words "transgender" and "child" together can be seen as an aberration. As Andrew Solomon (2012) notes, "Being trans is taken to be a depravity, and depravities in children are anomalous and disturbing" (p. 600).

The vast majority of gender-variant children are what Hellen (2009) describes as "non-apparent," and that is children who suppress their gender-nonconformity as a consequence of parental and/or societal pressure (see also Kennedy & Hellen, 2010). This is especially the case for gender-nonconforming boys who tend to generate greater cultural anxiety than do girls (Feder, 1999; Sedgwick, 1991). In many cases, parents and other concerned family members will thus actively discourage, if not outright forbid, their "little man" from participating in what they deem to be "girl" activities. And while many of them, no doubt, are deeply concerned about keeping their child safe from the ignorance of others, few caregivers are able to get beyond their own sense of loss and shame to allow their "son" or "daughter" to appear publicly (or even privately) in accordance with the gender expression with which the child is most comfortable (Ajeto, 2009).

In Canada the parental desire to "cure" the gender-variant child has been compounded by the work of Dr. Kenneth Zucker, a highly influential psychologist who has been treating and publishing about gender-variant children for more than twenty-five years. At the Centre for Addiction and Mental Health in Toronto, Zucker is Psychologist-in-Chief and Head of the Gender Identity Service in the Child, Youth, and Family Program. He and his colleagues have developed a controversial form of gender reparative therapy to encourage gender-nonconforming children to identify with their sex assigned at birth, and thus avoid what they see as an undesirable future of the child growing into a transgender adult (see Tosh, this volume). Working from the assumption that gender identity is malleable in early childhood, and that interventions are necessary to shield the child from the discrimination of society as well as to resolve disturbed attachment issues with the mother (a form of "psychopathology"), they advocate gender-variant children play with same-sex peers and that parents set limits on cross-gender presentation and play (Zucker, 2008; Zucker & Bradley, 1995). Not surprisingly, reparative therapy has been strongly criticized for being homophobic, transphobic, and misogynistic (Bryant, 2008; Feder, 1999; Isay, 1997) and has recently been rendered illegal in some states (Eckholm, 2012).

Some of the worst violence (threatened and realized), it should be noted, has taken shape in the context of conservative religious communities. In a biblically based world in which God has created only "man" and "woman," the gendercreative child serves as a living rupture to the perceived natural order of things.

But while the majority of fundamentalist religious adherents would forswear physical violence as an acceptable response to transgender children and their families, many see reparative therapy as appropriate. And, indeed, this is the official position of Focus on the Family, to name just one Christian organization to have engaged the issue.⁸ For a child to be subject to gender correction because they are viewed as psychologically ill (as is purported by some researchers, such as Zucker and his colleagues) is one form of violence. For a child to be subject to gender correction because they are otherwise not acceptable in the eyes of God is quite another. Indeed, for the many gender-creative children growing up in deeply religious families and communities, spiritual violence may be one of the greatest threats of all.

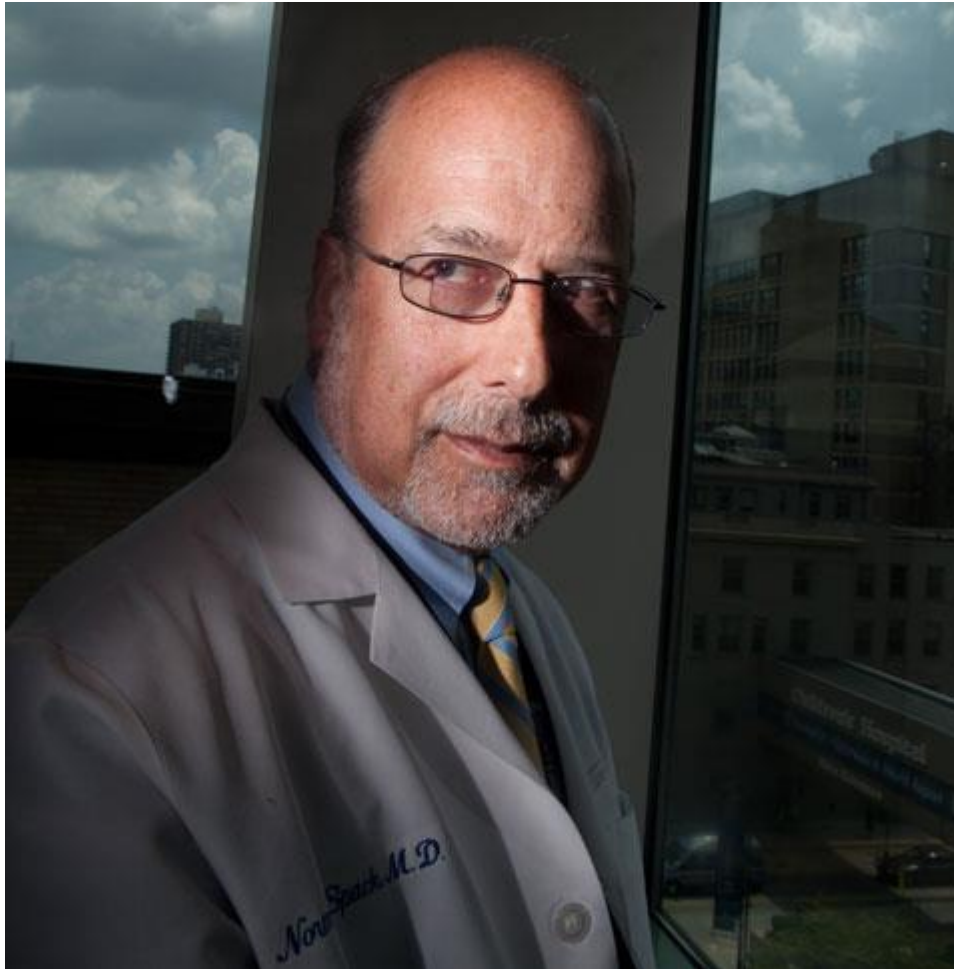
The "invisibility" of childhood gender-creativity, thus, is a direct symptom of the systemic violence brought to bear on children who dare to deviate from gender-normative expression. But this invisibility comes at a grave cost. When repeatedly isolated and attacked, many end up internalizing the violence. The fact that close to half of trans youth seriously consider or attempt suicide, we argue, is nothing less than a social crisis of acute proportions (Clements-Nolle, Marx, & Katz, 2006; Durso & Gates, 2012; Grossman & D'Augelli, 2007; Scanlon et al., 2010).⁹

How Norman Spack transformed the way we treat transgender children

Lifestyle Features

The Metamorphosist

By BETH SCHWARTZAPFEL | August 10, 2012



"Gender dysphoria is a condition that can be treated rather easily," he says. "You don't need to be a rocket scientist to take care of a transgender patient."

At 20, Norman Spack learned the power of hormones. By adjusting the prolactin and thyroid levels of tadpoles, Spack found he could prompt metamorphosis; he watched from a bench in his research lab as they grew legs and their gills were absorbed and replaced with lungs.

Forty years later, a patient named Mark walked into Spack's adolescent medicine clinic in Chestnut Hill and told Spack he wanted to change. He was male, he told Spack, but his body was a woman's. Back then, in the 1980s, many doctors might have seen Mark's predicament as a mental-health problem: someone with a desire that challenged the status quo of society and gender must need a psychiatrist, not an endocrinologist. But Spack approached the personable young man in much the same way he had approached his research on newts: Mark had a practical problem, and Spack had the tools to address it. "I had given plenty of testosterone to hypo-gonadal males," he recalls. "It just seemed to me you'd give the same amount you'd give a guy." And that's what he did.

Now nearing 70, and at the edge of retirement, Spack has gone on to change how transgender kids are treated. When he founded the Gender Management Service, or GeMS, at Boston Children's Hospital in 2008, it was the only pediatric clinic of its kind in the US. Adapting protocols developed by doctors in the Netherlands — the "Dutch masters," he calls them — Spack was one of the first doctors in the United States, certainly the first based at a major urban academic children's hospital, to try to tackle this problem, treating kids as young as nine with hormone blockers to delay puberty.

Today, clinics for transgender kids in British Columbia, San Francisco, Los Angeles, Chicago, Denver, Minneapolis, New York, Hartford, Providence, and Washington, DC, have either been created or expanded. And in almost all of these places is a doctor that Spack has trained, mentored, or guided.

"As centers like Norm Spack's are starting up in a number of places, a lot more pediatricians and a lot more child psychiatrists will be educated about this issue and will be able to refer children," says Laura Erickson-Schroth, a psychiatry resident at NYU and a former student of Spack's who is helping to set up a clinic like GeMS in New York. This is both a result of Spack's work and a sign of the times. As a result, "as a society, we're sort of beginning to accept that gender and sexuality are not straightforward and simple."

Spack, for one, understands transsexualism as a straightforward medical issue. "This is two conditions that pediatric endocrinologists treat all the time," Spack says. "One is precocious puberty. The other is delayed puberty. So for the transgendered, it's the precocity of the puberty they never wanted, and a delay of the puberty they affirm."

"Gender dysphoria is a condition that can be treated rather easily," he says. "You don't need to be a rocket scientist to take care of a transgender patient."

For decades endocrinologists have been treating transgender adults with cross-gender hormones: testosterone if you're female-to-male, and estrogen if you're male-to-female. This is nothing new. But for kids like Spack's patient Justine (names have been changed to protect the identities of the children and their families), who, from the moment she could speak, "told us she either wanted to be a girl or she was a girl," as her dad describes it — kids who can articulate their gender identity, without a shred of doubt, from the time they are toddlers — waiting until after puberty means years of psychological agony; girls develop thick muscles and deep voices, and boys grow breasts and hips and get their period. The risk for self-harm during this time is enormous; among Spack's patients, one in five has engaged in cutting or other self-mutilation, and almost 10 percent have attempted suicide. Waiting to intervene until after puberty also means playing catch-up physically, with more medical interventions and more extensive surgeries required to "pass" in the right gender as teenagers and young adults. Unlike the cross-gender hormones that kids may start later as teenagers, the effects of the puberty suppressors are entirely reversible: adolescents who stop taking them will immediately begin to experience puberty in their birth sex. The idea is to buy them some time. Time to grow up, time to develop what Spack calls "clarity and certainty" without the stress of their unwanted puberty bearing down with increasing intensity every passing day.

For the first nine years of his life, Aileen Smith's son hated his name. It's a girl's name, and not only couldn't he bring himself to say it aloud, he couldn't even be friends with girls who shared it. When he first went to see Spack, the boy — who later named himself Kyle — had a flat chest and lanky body. But he was only nine. That would soon change.

Spack told them that Kyle would get his period within a year and a half. He'd also start developing. He would likely be a C cup.

You can almost hear Kyle's breath catch in his throat as his mom recalls this visit. "Geez," he whispers. He sinks deeper into the ottoman where his legs are folded underneath him.

Now 15, Kyle is a sensitive young punk kid with a floppy brown Mohawk, a blue lip piercing, and a set of rainbow rings around his neck. He is happy and easygoing, well-liked at the lefty private high school where he's just finished his freshman year, and close with his family. When he first met Spack, though, he had for years felt so uncomfortable in his own skin, that he developed paralyzing anxiety; he refused go to school, lest he'd have to talk to someone, or worse, introduce himself.

Kyle only recalls his first appointment in bits and pieces. Many memories of his life before age nine are this way. He can't — or won't — remember them. But he does remember looking at Spack as "some kind of god" when he told him that there was another way. And he does remember when Spack told him that without intervention he was going to be, physically, a well-developed young woman within the year.

"Shit flew off the hook," Kyle says.

Doctors and other providers working with transgender patients typically "have some sort of personal connection, whether through their politics, or they were in the LGBT community already," says Spack's former student Erickson-Schroth. Spack, on the other hand, "came to this by accident. He just saw there was something wrong in the world, and he did something."

Spack grew up in a conservative Jewish community in Coolidge Corner, where his father ran a Hebrew school and was devoted to their local synagogue. Although as a kid Spack looked up to his dad's best friend, their family physician, he never seriously considered medicine as a career until his senior year of college.

It was an accident, really, dumb luck that led him to a senior biology thesis that would set the course for the rest of his career. A student before him had been working with newts and other amphibians, and an ecology professor invited Spack to continue the research the other student had started. And so Spack sat on that research lab bench, watching the tails of these aquatic animals shrink and their legs grow for their new life on land.

The parallel isn't lost on him: he chuckles now to think of himself as a college student, using many of the same hormones he uses now, to much the same effect.

Spack went on to medical school, and then post-graduate training in adolescent medicine and endocrinology. And among a certain subset of the endocrine patients he saw in his adolescent medicine clinic, he discovered something unsettling: "Sometimes there was a kind of conspiracy between the doctors who cared for them years before, and the parents," says Spack. A conspiracy "to not tell what had happened to them."

As many as one in 100 babies are born with genitals, chromosomes, hormonal systems — or some combination of these — that don't fit the standard parameters for male or female. Today, treating kids with what are now known as "disorders of sexual differentiation," or DSD, is one of GeMS's specialties, and Spack routinely helps families decide whether to raise their child as male or female and weighs in on whether and when surgery is required. In making this decision, they consider "diagnosis, genital appearance, surgical options, need for lifelong replacement therapy, potential for fertility, views of the family, and, sometimes, circumstances relating to cultural practices," Spack and his colleagues wrote in a landmark 2006 consensus statement in the journal *Pediatrics* on the management of intersex disorders.

But these guidelines were developed partly in response to increasingly vocal activists like Intersex Society of North America founder Cheryl Chase, who as an infant had her clitoris surgically shortened. Before people like Chase began to speak up in the early '90s, parents of these kids — even babies who were unambiguously sexed except for a particularly small penis or a large clitoris — were often pressured into sex reassignment and early genital surgery to make their infants appear more "normal." In some cases, the condition was treated as an emergency, and parents were not even consulted until after the surgery was over.

By the time Spack began his adolescent medicine practice, it was not uncommon for him to meet teenagers who had never been told that these surgeries had been performed on them as infants. "In the days before the computer, you could seal medical records," Spack recalls. "You could literally control that information." But one of the reasons Spack was drawn to working with adolescents in the first place was that he liked to have independent relationships with his patients — developing trust with teenagers gave him a "direct line" to them that bypassed their parents — and he felt strongly that these kids needed to know what had happened to them.

"This was in an era when chromosomes were so important," says Spack. "If somebody's chromosomes didn't match the way they were raised, many parents didn't want the kids to know." For instance, he saw young women who "never knew that they were born with a male set of chromosomes. There were a number of circumstances where I would tell them and make them understand how meaningless their chromosomes were." The parents feared that the information would "do something to their gender identity," but Spack consistently found that it didn't.

While he worked with young intersex patients during the day, at night he volunteered one evening a month on a medical outreach van with the organization Bridge Over Troubled Waters. Here he encountered members of the LGBTQ community professionally for the first time. The "Bridge kids" were hustling for sex, some of them in drag bars, dressed as women.

Spack wasn't sure whether they were gay, transsexual, or just runaways doing what they needed to do to get by.

"I was naïve," he says now. "I thought that all the kids I saw in the streets were runaways. And I had been told about the rules about runaways, like that they could be housed for three days without calling the parents. But one of the street workers said, 'They call them runaways. These kids are throwaways. Our goals aren't to get the kid home. Home is not a safe place.' "

His 10 years working with Bridge kids left a lifelong impression on Spack, who is acutely aware of the "kind of ideal world" that GeMS selects for when it screens its patients. "Both parents have to agree, and you have therapists who have weighed in, good people you trust."

This, he knows, is sadly uncommon. Even transgender children with one supportive parent, he says, are "one parent away from being a Bridge kid."

For Kyle Smith at age nine, the first two of GeMS clinic's three requirements to begin puberty blockers were easy: extensive psychological testing confirmed that he had a "strong and persistent" desire to be a boy, and ongoing mental-health counseling was also covered: he'd been going to therapists for years. But the third requirement — support of both parents?

"Fathers often do come around a little later," Aileen says of her husband. "Medical things are so hard. He was supportive, but he was saying, 'Let's see. This could be a phase. How do we know?' "

For Kyle at that first appointment in Spack's office, the stakes couldn't have been higher. "He walked up to his dad, and looked at him as if he was like a teenager, but he was only a little boy," Aileen recalls. "He must have been thinking, 'I didn't come this far to be told that I have to leave and not get help.' He said, 'Dad, I need help. You need to help me. You need to tell Dr. Spack. I need medical help.' He literally said those words: 'I need medical help.' " Aileen looks at Kyle now, who is fiddling with a rubber rainbow bracelet. "And Dad started crying."

"I really don't remember that," Kyle says. "I wish I did. I can't picture that at all. I've never seen my dad cry."

Aileen nodded. "Dad started crying and he looked at Dr. Spack, and he said, 'I understand. You need to help my son.' And that was the beginning."

Happy with the treatment he received from Spack, Mark referred his friends, and his friends referred their friends, and soon Spack had a busy practice of transgender teenagers and adults. Doing this work, he was often struck by "how difficult it was, particularly for male-to-females who were undergoing

transition in their 30s and 40s," he recalls. For those who had completed puberty in their birth sex 20 and 30 years before, hormones and surgery could only do so much. So when, in the early 2000s, he heard about a new Dutch protocol which could prevent the onset of puberty in young trans people, he was intrigued.

He was a pediatrician, after all, and together with the administration at Boston Children's Hospital — where he was transitioning to a full-time position — Spack decided to transfer all of his adult patients to other providers in order to focus solely on kids. He personally trained many of these doctors who went on to care for his adult patients. One of them was Alex Gonzalez, medical director of Fenway Community Health Center.

The Fenway has 800 patients in its transgender health program and is considered one of the nation's premiere medical centers specializing in care of the LGBTQ community. Indeed, you might think they had a strong transgender health program from the start. But "of all the many different people we've had to come help us build our program here," says Gonzalez, "Dr. Spack stands out as one of the most instrumental." Spack's "Transgender Health 101" presentation some six years ago, and his ongoing support, has helped to quadruple the program's size. "Probably the most attention-getting aspect of Dr. Spack's approach is that it really isn't sensationalistic at all," says Gonzalez.

At the time, Spack had colleagues who wanted to start a program like GeMS, but they faced unsupportive department chairs reluctant to intervene medically "in a pediatric population deemed to have a primary psychiatric problem," as Spack describes it. "They said, 'You guys have got to be nuts, doing this in a pediatric hospital.' " But the administration at Children's was on board from the start. Joseph Majzoub, Chief of Endocrinology at Children's, who years earlier had helped arrange a special rider on Spack's malpractice insurance to allow him to see transgender adults, encouraged Spack to pursue puberty suppressants, the newest approach to treating transgender kids.

"The guiding principle should be what's best for the patients," Majzoub says. "Norm has been very crystal clear in his thinking about this and his commitment. He made it easy. I don't know what the biases might have been elsewhere, but when one takes one's cues from what the patients need, you're usually right."

Kyle Smith had crushing parental separation anxiety and, until he was 10 years old, not a single friend in the world. How could he? He couldn't even say his own name. He had not gone to school for more than a week since first grade. His family and the school had tried everything, from a rewards system to the principal carrying him physically into the building, but it was never long before he had a massive anxiety attack and had to go home.

"Dr. Spack and his team told us that his anxiety, his school, everything would be fine, when he lived fully as a boy," recalls his mom, Aileen. "And of course they were right. Everything." They had to move from a small college town in central Maine to another city in that state in order to do that — they later won a large settlement from their original school district when the school superintendent refused to cooperate — but once he walked into the first day of sixth grade at his new school with his new name, his male pronouns, his boy haircut, and boy clothes, he introduced himself to his new friends and never looked back.

As kids like Kyle become increasingly more accepted, and as access to care becomes easier, critics on both the left and the right of Spack's pragmatic, supportive approach fear that Spack and those like him are making it too easy for kids to transition.

"If you put a kid on blockers, in a way the clinician is giving either an implicit or explicit message that we don't really see that there are alternatives than to go down a sex-reassignment pathway. And we don't really see it as possible that there could be other outcomes that may be equally as good — maybe even better for some kids," says Dr. Kenneth Zucker, head of the child and adolescent gender identity clinic at Toronto's Centre for Addiction and Mental Health.

Accused by some of practicing "reparative therapy"— he encourages parents to stop their young gender-variant kids from experimenting with opposite-gender names, toys, and clothes — Zucker is something of a *bête noir* in many trans communities. But he feels strongly that "if a child can grow up and feel comfortable in his or her own skin that matches their birth sex, then you avoid the complexity of fairly serious surgical treatments. Penectomy and castration is not the same thing as having mild and minor cosmetic surgery. Lifelong hormonal therapy: it's serious."

On the left are critics who dislike the binary model that GeMS inevitably plays into. "Sometimes when I speak in a binary model, people are critical of that," says Spack. "They want more fluidity about gender." As an endocrinologist, Spack can only treat those trans kids who want to be either boys or girls: there can be no gray about it. His hormones and pubertal suppressors would be of no use to other kids — and the intervention is too serious for him to consider using with kids who might later change their minds. Still, he's not advocating that kids need to live in a binary if that's not right for them. "I would [defend] the right to be genderqueer just as much as I would defend the transgender person's right to be in the gender they affirm," he says. "So when people come up to me, I say, 'You know, you of all people should be sensitive to the fact that in my accepting you, you have to accept them.' "

Whether transsexualism is a medical or psychiatric issue — or an issue at all — is more than a rhetorical question. According to the American Psychiatric Association, Gender Identity Disorder (or GID, diagnostic code 302.6–302.85) is a mental disorder: it has been classified as such in the Diagnostic and Statistical Manual, or DSM — the bible of psychiatric illness — for 30 years now. A new volume, DSM-V, is currently being researched and written, prompting vociferous debate about whether trans people warrant a psychiatric diagnosis — and, if so, what to call it. (In the new edition, due out in May 2013, GID will likely be renamed "gender dysphoria." Over the protests of many trans activists, Zucker is chairing this committee.)

Hormones and surgery cost tens of thousands of dollars, and whether these are covered by insurance hinges, in part, on whether kids have a formal medical diagnosis. Spack sees families all the time whose insurance companies refuse to cover pubertal suppression because their gender dysphoria is classified as a psychiatric illness. But it seems clear to him that whatever mental distress these kids are suffering is the result of their medical problem. With treatment, he says, "You treat not only the medical hormonal deficiency, and help them attain the body that they wish, but you are very likely to erase a whole bunch of psychopathology that's all secondary."

He has seen this over and over again in patients like Kyle: once they are able to live comfortably in their affirmed gender, their anxiety and depression — even bipolar disorder — disappear. Spack says that even mild autism in trans kids (studies show that 10 times as many gender-variant kids than kids in the general population have autism-spectrum disorders) may be alleviated with treatment for gender dysphoria: "Perhaps the social awkwardness and lack of peer relationships common among GID-Asperger's patients is a result of a lifetime of feeling isolated and rejected," he wrote in a recent article in the *Journal of Homosexuality*; "and maybe the unusual behavior patterns are simply a coping method for dealing with the anxiety and depression created from living in an 'alien body,' as one patient described it."

For Kyle's part, now that he has less to prove with regards to his masculinity — he has been on testosterone for more than a year and lives fully as a boy — he has chosen to express his boy-ness in a less "binary" way. "I'm not exactly the most masculine of masculine," Kyle says. He feels freer to express what he calls his "feminine side," sewing, knitting, and shedding the emphatically masculine clothes he used to wear in favor of more gender-neutral or feminine attire, like wrists full of beaded bracelets. He has become deeply involved in the Trans Youth Equality Foundation, a national organization that provides support and education for families and communities of trans kids. He

Human Rights Complaint 034 to UN

recently came out as gay. And he has stopped being "stealth" at school and started telling friends about his experience.

As for GeMS, since its founding, it has grown into a multidisciplinary clinic, with a team that includes a psychiatrist, a psychologist, a urologist, a gynecologic surgeon, a specialist in genomics, and a social worker. They have developed a careful algorithm: families do a preliminary intake with an administrator first, then a more thorough intake with a social worker, followed by exhaustive testing by a psychologist, before they ever set foot in Spack's office. That's how it's designed to work, anyway, and it's largely set up to save Spack time and trouble; patients who are too young, or are not totally sure they want to transition, are referred for further therapy or counseling. But as often as not, Spack thinks of kids like Kyle, and is so eager to end their suffering that he just picks up the phone himself.

Victor Samuels, father of Spack's patient Justine, e-mailed Spack when his daughter was 11. The reply came the next day, Samuels recalls.

" 'I have a six-month waiting list,' " Spack told him, " 'but I'll see if I can get you in earlier.' Ten o'clock that night I get a phone call at home. It's Dr. Spack. He says, 'I have a cancellation tomorrow at 10. Would you and your wife like to come in to see me?' "

Justine is now 13, and "sometimes I actually have to remind her," says Justine's mom. "If you look at so many other transgender individuals who have had to figure out how to take back certain things: how to become more feminine, how to become more masculine. And she's been able to stop time. And stop this puberty. We're sometimes like: 'You don't know how lucky you are.' "

On the day I met her parents, Justine was at cheerleading tryouts. "At my chagrin," her mom said, laughing. "But she's there."

In 2009, Spack co-authored the Endocrine Society's first-ever clinical guidelines on treatment of transsexuals, and this year *Pediatrics* published an article in which Spack describes GeMS and his clinical approach; this article — the first time treatment of trans kids has been described for a general medical audience — was a real coup, since primary care pediatricians are often the first person a parent turns to for help with a gender-nonconforming kid.

Alongside Spack's pragmatism and his protectiveness of his patients — his insistence that taking care of them is just like taking care of any other patients — is an enduring sense of wonder at stories like Kyle's, at the kinds of transformations that something as simple as hormone re-regulation can help facilitate. This is a source of great comfort and satisfaction for Spack as he looks toward his retirement. It feels good, he says, "watching kids move confidently through life. Feeling that they're not crippled. But that's also a dual thing. That's both a hormone and a receptor, you know?" he asks, ever the endocrinologist. "The kid is the hormone who's had changes that enable them to be accepted, but they're also entering a world that's more accepting."

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Read more: <http://thephoenix.com/boston/life/142583-how-norman-spack-transformed-the-way-we-treat-tran/#ixzz3ADadBxr4>

Chapter 16

The Impact of Stigma on Transgender Identity Development and Mental Health

Walter Bockting Columbia University

Abstract

The existence of transgender and gender-nonconforming people has been documented throughout history and across cultures. In the twentieth century, transgender expression became medicalized and sex reassignment became available, initially enforcing a binary understanding of sex/gender as either male or female, man or woman, and masculine or feminine. The goal was to adjust and live either as a man or as a woman, evading the social stigma attached to gender nonconformity.

However, it quickly became clear that stigma was pervasive and continued, even for those who fully transitioned to living as a member of the other sex. Transsexual and transgender individuals found support among each other, affirmed their specific identity and experience, and advocated for their rights. Since the 1990s, the paradigm shifted toward (re)discovery of a spectrum of gender diversity.

Transgender is now an identity, no longer a disorder, and identifying as such is for many an important part of their coming-out process to affirm their differentness, find belonging in a community of peers, challenge stigma, and advocate for inclusion, respect, and acceptance. Research has established the association between discrimination and psychological distress, with family support, identity pride, and particularly peer support serving as protective factors. What is needed is a greater understanding of the mechanism of stigma, both for the minority population and for the sociocultural context in which stigma is produced and perpetuated, to inform policies promoting transgender rights and resilience.

16.1 Historical Background: From Gender Nonconformity to Sex Change

The existence of gender-nonconforming and transgender people has been documented throughout history and across cultures (Bullough & Bullough, 1993 ; Feinberg, 1996). Examples of such gender diversity include “two-spirit” individuals in Native American tribes (Roscoe, 1991 ; Williams, 1986), “acault” in Myanmar (Coleman, Colgan, & Gooren, 1992), “maa khii” in Thailand (Taywadietep, Coleman, & Domronggittigule, 1997), “travesti” in Brazil (Kulick, 1998), and “hijras” in India (Nanda, 1999). In the Netherlands, Dekker and van de Pol (1989) reported more than a hundred cases of female cross-dressing (females dressing as men) in the seventeenth and eighteenth centuries. While motivations for crossdressing and living as man varied (e.g., economic, psychological, sexual, taking on roles only acceptable for men), experiences of stigma (e.g., fear of discovery, negative social reactions) were common across this group despite the popularity of cross-dressing and crossgender behavior in art and folklore.

In the nineteenth century, however, cases of female cross-dressing declined markedly, attributed to increased societal barriers (e.g., enforced military service, civil registration, medical exams). The authors concluded that female cross-dressing and living in the male gender role were perceived as threatening the hierarchy between the sexes and that gender ambiguity seemed to put people ill at ease.

In the early twentieth century, when males who cross-dressed faced legal arrest, Hirschfeld (1910 /1991) advocated for them by medicalizing transgender expression. He argued that instead of criminalizing cross-dressing and crossgender behavior, people needed to be compassionate as he believed the behavior involved an innate orientation.

In the second half of the twentieth century, after behavioral therapies aimed at changing gender identity/expression to become congruent with sex assigned at birth had failed, advances in medical technology were applied to attempt to achieve the opposite: to change an individual’s primary and secondary sex characteristics to become congruent with their perceived gender identity (Benjamin, 1966 ; Green & Money, 1969 ; Hastings, 1974). Indeed, this approach of sex reassignment became known in the popular vernacular as “sex change” (Meyerowitz, 2002). While Benjamin (1966) acknowledged a spectrum of transvestism and transsexualism, much of the focus shifted toward selecting appropriate candidates for hormone therapy and surgery who could successfully “pass” and assimilate as members of the “opposite” sex. The aim was to alleviate their suffering by facilitating a change in sex while minimizing the risk of regret of undergoing irreversible medical intervention (Hastings, 1969 ; 1974 ; Hastings & Markland, 1978).

Also in the Netherlands, sex reassignment became available coordinated by the *Stichting Nederlands Gender Centrum* (de Vaal, 1971 ; Verschoor, 1986). The VU University Medical Center (VUmc) provided hormone therapy and surgery (Gooren, Asscheman, & Megens 1986). Post hoc follow-up research supported the value of sex reassignment in alleviating gender dysphoria: The vast majority of transsexual individuals who received hormone therapy and had sex reassignment surgery reported satisfaction (Kuiper, 1991), and reports of regrets were extremely rare (Kuiper & Cohen-Kettenis, 1998).

The VUmc became an international leader in patient-oriented research reporting on the long-term effects of hormone therapy in a large cohort of transsexual adults (e.g., van Kesteren, Asscheman, Megens, & Gooren, 2003).

Initiated in collaboration with Utrecht University, the Dutch also pioneered early medical intervention in the form of puberty-delaying hormones followed by cross-sex hormone therapy (Cohen-Kettenis & van Goozen, 1998 ; Delemarre-van de Waal & Cohen-Kettenis, 2006), which has now become an approach applied worldwide (Coleman et al., 2012).

Moreover, research at the Netherlands Institute for Brain Research showed that an area of the hypothalamus of the brain of transsexual women was more similar to that of nontransgender women than to that of men (Kruijver et al., 2000 ; Zhou, Hoffman, Gooren, & Swaab, 1995). At the height of the sex change paradigm in the Netherlands, some argued for replacing the term “sex reassignment” with *detransseksualisatie* (detranssexualization) to affirm transsexual (or, rather, “transsexed”) individuals’ lifelong core crossgender identity and the success of the available treatment to fulfill their need to live as members of the “opposite” sex (Kuiper, 1991 ; Verschoor, 1986).

16.2 Social Stigma: From *Detransseksualisatie* to Transgender Coming Out

Since the 1990s, first in the USA and subsequently also in Western Europe, the paradigm shifted from seeing gender identity as binary (either boy/man or girl/woman) toward (re)discovery of a spectrum of gender diversity. As a generation of sexreassigned transsexuals came of age, recognition grew of a transsexual or transgender identity “outside the boundaries of gender, beyond the constructed oppositional nodes” of male versus female (Stone, 1991 , p. 295). Transsexual and transgender individuals began to affirm their identity as distinct from nontransgender women and men, honoring their specific experience and roots (e.g., Bornstein, 1994). This change in paradigm can be understood in the context of social stigma. As Pfäfflin (2011 ; see Chap. 17) argued, identity becomes relevant when it is no longer assumed but questioned, when we are dealing with a deficit. Thus, the social stigma attached to gender nonconformity (deficit) created the need to “come out” and affirm an identity that transcends the gender binary.

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How Living With and Loving Bruce Jenner Changed My Life Forever by linda-thompson

Actress, Songwriter, Television Personality

http://www.huffingtonpost.com/linda-thompson/bruce-jenner-linda-thompson_b_7080918.html

Editors' note: Though Jenner has come out as "for all intents and purposes a woman," *he has not yet indicated* that he would like to be known by a new name or female pronouns, so this story uses male pronouns.

MCB Note: Since the article was published, Bruce chose the name Caitlin Jenner.)

Posted: 04/24/2015 10:59 pm EDT Updated: 04/24/2015 11:59 pm EDT

By now, Bruce Jenner has revealed his struggle with gender dysphoria.

I never would have dared to speak on this issue before he was comfortable enough to do so first. It is, after all, *his* truth, so I knew he should be afforded the dignity to reveal that truth on his own time and in the way he sees fit.

I have respectfully kept his secrets private and would have taken his confidences to my grave had he not spoken out.

But now, many years into his remarkable life, he has spoken out. His legacy will likely be sprinkled with references like "Olympian," "decathlon gold medalist," "world's greatest athlete," "son," "brother," "husband," "father," "grandfather," "friend," and, hopefully, "pioneer" and "trailblazer for the civil rights of the transgender community."

So as much as this is about Bruce, it's not all about him. The sharing of my experience is meant to enlighten and inform -- to lend a modicum of comfort and support for all those disenfranchised, struggling, discriminated-against, searching souls.

Bruce's story and his struggle are uniquely his; my experiences with Bruce are commensurately uniquely my own.

Following is a brief history of my time with Bruce -- a life experience that shaped my existence immeasurably.



* * * * *

One hot Memphis night in July 1976, Elvis (yes, *that* Elvis) and I were watching the Summer Olympics that were being held in Montréal.

We were lying in bed (our usual perch) at Graceland and had been watching the telecast for days. We were pretty closely following the American athlete Bruce Jenner, who was dominating the decathlon competition. Bruce was on the final lap of his last race, the 10th event, and as he crossed the finish line to win the Olympic gold medal in the decathlon competition, distinguishing himself as the "world's greatest athlete," Elvis and I were exuberant about the win for the United States! We were also commenting on what an amazing specimen of a man Bruce Jenner was. Elvis remarked, "Damn if that guy is not handsome! I'm not gay, but damn, he's good-looking!" I quite agreed and teasingly said, "Wow! He is gorgeous! I'm going to marry that guy someday!" Elvis replied, "Yeah, sure, honey, over my dead body."

I met Bruce Jenner at a celebrity tennis tournament three years later, in the spring of 1979. The tournament was a benefit for the John Tracy Clinic for deaf children. The event was held at the Playboy Mansion. I had never been to the mansion before, but Bruce had been living there part-time since his separation from his then-wife Chrystie.

Human Rights Complaint 034 to UN

I was a regular cast member on the TV variety show *Hee Haw* and a fledgling actress of some note (think Aaron Spelling shows), so I was invited to the mansion to hand out the winning trophies to the participants playing tennis. No surprise, Bruce won the tournament, and I presented him with his trophy. That's how we first met, on a tennis court.

Bruce was clad in shorts and a sweaty T-shirt, his well-toned, muscular body still in Olympic form. He was sweet, shy, and very gentlemanly. He asked me if I came to the Playboy Mansion often, and I said, "Oh, gosh, no! I've never even been here before!" I remember thinking I didn't want to give him the wrong impression. I didn't want him to think I was an aspiring Playmate!

His friendliness became a little flirty, so I asked him outright, "Hey, aren't you married?! I watched you win the Olympics, and as I recall, your wife was very present!" Bruce's whole demeanor changed as he sadly responded, "No, I'm separated, and it's really not a lot of fun." He seemed so childlike and lost in that moment that my heart truly went out to him. I said I was sorry to hear that, and we continued to chat for a while, still on the court.

Everyone at the John Tracy Clinic event was reconvening for dinner after tennis, and Bruce had planned to go home, shower, and change clothes before coming back to the event for dinner. However, he kept hanging around and finally explained, "I really don't want to leave you alone here, even for a little while. I've seen how George Peppard and others are looking at you and just waiting for me to leave so they can hit on you."

I thought, "How charming and gallant!" Bruce stayed in his shorts and T-shirt while others were dressed for dinner, and he and I continued to get to know each other. Bruce asked me out for dinner, and, of course, I said yes. Thus began a romantic relationship that lasted several years and produced two wonderful sons.

Bruce already had an adorable young son named Burt, and during a brief reconciliation with Christie, they were blessed with a beautiful baby girl named Cassandra. Burt and Casey (as I call her) have always been a tremendous blessing and gift to my life.

During the course of our dating, Bruce and I traveled to Australia to promote his upcoming film with the Village People, *Can't Stop the Music*. Alan Carr had produced the movie, and we became fast friends. Alan was very flamboyant, funny, creative, and generous. Alan insisted that, on our return trip from Australia, Bruce and I let him treat us to a pre-honeymoon of four days on the incredibly gorgeous island of Bora Bora in Tahiti. Bruce and I had a relaxing and romantic time on this enchanting island. We stayed in one of those thatched-roofed, over-the-water huts, so we could just step off our deck into the crystal-clear water and be swimming with the multicolored fish instantly. At night we would lie under the stars and talk about our future and the magical quality of the universe in which we lived.

The Bruce I knew back then was an easygoing, down-to-earth, casual, romantic, good and loving man. I was extremely happy to have found such a remarkable partner with whom to share my life. I found him to be honorable and, well, just too good to be true. Just too good to be true indeed.

I found myself pregnant for the first time in my life. When the doctor's office called me to tell me the results of the pregnancy test, I fell to my knees with joy and prayed that I would be worthy of carrying that precious life. It is a feeling I'll never forget. I really felt in that moment that whatever had transpired in my life of any negative nature, any transgression I had ever perpetrated, had somehow been cleansed away from my being. This was a new start for my life. Clearly I was deliriously delighted with the news.



* * * * *

Bruce and I were married Jan. 5, 1981. We were married at the beautiful, beachfront Hawaiian home of Alan Carr. There were only about 35 people in attendance, including our parents. Bruce's son Burt served as the best man, even though he was only 2 years old and was constantly interrupting our nuptials with "I want up." It was very sweet and lent a warm, familial touch to the ceremony. My nieces, Jennifer and Amy Thompson, served as the flower girls, and my sister-in-law Louise was my matron of honor. It really was quite an extraordinarily beautiful wedding. We said our I-dos at 6 p.m., just as the sun was setting over the placid, blue Pacific Ocean. It should be noted that Bruce was a very secure man, because the music I chose to walk down the aisle to was Elvis Presley's "Hawaiian Wedding Song." It had always been my dream to get married in Hawaii. It was a dream that had been spawned by Elvis' movie *Blue Hawaii*. I had watched that movie over and over as a little girl and always thought, "How very romantic it would be to get married in such a beautiful paradise!" To Bruce's credit, he went along with my fairytale plans for a cinematically inspired, sunset wedding in Alan Carr's Japanese garden at the base of Diamond Head, on Waikiki Beach, on the beautiful island of Oahu, Hawaii. Only Elvis was missing in my fairytale wedding.

Brandon Thompson Jenner was born June 4, 1981. I thought I knew what love was before giving birth to my baby, but whatever I had experienced in the past paled in comparison to the utterly unconditional love I immediately felt for the little bundle I now held in my arms. Burt and Casey came to the hospital and got to see and bond with their new little brother Brandon.

Those were very happy days for me. I truly loved Burt and Casey, and Brandon was the absolute sunshine in every day of my life! This newfound motherhood thing seemed to be my natural calling in life. I had already practiced on Burt and Casey, since Bruce and I frequently had them in our home, and they were still very young. So I felt prepared to be a mommy to Brandon. I loved having this little ready-made family to enjoy and spend time with.

Bruce and I actually made quite a great couple at the time. We got along exceedingly well and enjoyed many of the same activities, once he taught me how to do the sports that he enjoyed. Bruce taught me how to jet ski, water ski, snow ski, play tennis, eat healthfully, work out regularly, and basically lose my fear of getting my hair wet and opening my eyes underwater. Well, I may be exaggerating about losing my fear, but it is fair to say that Bruce unleashed a natural athlete in me. I became a pretty good tennis player, and Bruce and I even hosted our own celebrity tennis tournament benefiting United Cerebral Palsy in Children for several years. It was called the Bruce and Linda Jenner Love Match.

Bruce and I appeared on red carpets regularly, and we were perceived as a "glamour couple." We also lent our time to charitable causes. We were the national honorary chairpersons of the Juvenile Diabetes Association and regularly supported the Special Olympics.



* * * * *

One day we got a call from the White House asking if we would be available to meet President Ronald Reagan in the Oval Office as representatives of the Juvenile Diabetes Association. I was still nursing Brandon, and the timetable was, basically, "We would need you here in Washington the day after tomorrow." We didn't want to miss the opportunity to have an audience with the leader of the free world, so I barely had time to store up some breast milk, find something appropriate to wear, and get on that plane to our nation's capital. It was a quick turnaround. We were back in Malibu in a matter of hours, but the honor of meeting the president of the United States is a lasting memory. I was very content to be back home in Malibu with my sweet baby Brandon in my arms and an interesting memory to tell him about when he was older.

Human Rights Complaint 034 to UN

Bruce possessed such a natural athleticism in everything he attempted to do. He seemed to excel in every sport he tried. Whatever he did, he was daring and cut an amazing form. Bruce was pretty much the perfect specimen of a man. Men aspired to be like him and wanted to hang out and play sports with him, and women were clearly attracted to him. The Bruce I knew back then was unstudied, affable, and seemingly very comfortable in his own skin. So it seemed.

One summer Bruce and I were asked to do a summer stock production of *Li'l Abner* in Birmingham, Alabama. We thought that sounded like fun, so we agreed to do it. Bruce was surprisingly very musical and liked to dance. We traveled to Birmingham and went into rehearsals. Of course we took Brandon along, and he had a great time parading onstage right along with us, in his very own Li'l Abner costume. We actually got good reviews, although I discovered live theater was incredibly nerve-racking. I had done plays in high school before, but this was a full-on musical and was really quite demanding.

Bruce and I spent our days living at the beach, jet skiing, walking on the beach every morning with our coffee, sailing on a Hobie Cat, playing tennis, and otherwise just enjoying each other and many of the same activities. I thought we lived a pretty idyllic life.



* * * * *

When Brandon was just over 1 year old, we thought it would be nice for him to have a younger sibling. Pretty soon I was delighted to be pregnant with my second son, Sam Brody Jenner. I named Brody after my brother Sam. Brody was born Aug. 21, 1983.

Those were the happiest days of my life. I had a wonderful husband, who was the most athletic, high-spirited, energetic, easygoing, *manly* man imaginable. I had two beautiful, healthy baby boys. I had two great stepchildren. Life was just about as good as it gets. We had moved into a sweet, one-acre mini-estate where I planted roses, fruit trees, and flowers, and where many lasting memories were made.

Bruce traveled a lot, doing motivational speaking, working for NBC SportsWorld, racing cars, and throwing himself into other assorted jobs and activities. I often accompanied him, always bringing our sons, and sometimes I stayed home with the boys while he traveled.

When Brody was about 18 months old and Brandon was about 3 and a half years old, Bruce came to me one day with a very somber look on his face and said, "There's something about me that I really need to tell you, something you need to know." I truly thought he might possibly tell me he had had an affair while on the road. But that's not what he wanted to confess to me. Bruce told me that he identified as a woman. Not understanding exactly what he meant, I questioned him. "What do you mean you identify as a woman?" I asked. "What does that mean?" He replied that it meant that for as long as he could remember, he had looked in the mirror and seen a masculine image staring back at him where there should have been a feminine reflection. Bruce lamented, "I have lived in the wrong skin, the wrong

body, my whole life. It is a living hell for me, and I really feel that I would like to move forward with the process of becoming a woman, the woman I have always been inside."

People have asked me, "Were there any signs or clues through the years that Bruce might have had this issue? Any evidence he wore your clothes?" No. Not a clue. Nothing. Nada. Never.

I would venture to say that 30 years ago, very few of us were adequately educated about the world of gender dysphoria. I certainly wasn't. I was living in my little Malibu cocoon of marital, motherly bliss with my world-champion, muscular, athletic, handsome husband. So my reaction to Bruce's shocking declaration was one of confusion, even desperation. I suggested that we go to therapy. I needed to understand fully what Bruce's issue was, and then to determine if it was something we could overcome or "fix." I was naïve. As I said, I was pretty ignorant of the fact that being transgender isn't something that can be overcome, fixed, prayed away, exorcised or obliterated by any other arcane notion. Being transgender, like being gay, tall, short, white, black, male, or female, is another part of the human condition that makes each individual unique, and something over which we have no control. We are who we are in the deepest recesses of our minds, hearts and identities. I had to learn that life lesson and apply it to my own expectations for my future and the future of my family.

I found a therapist who specialized in gender dysphoria. Her name was Dr. Gertrude Hill, and we began going to her right away. She was a lovely woman who very calmly, and as gently as she could, massacred me with the information that broke my heart into a million pieces. She told me in one of the first few sessions, "Linda, this is who Bruce is. His identity is that of a woman, and that will never, ever go away. You have a choice to make. If Bruce goes through with his gender reassignment, as he is now planning to do, you have the option of staying with him after *he* becomes *she*, or you can divorce him and move on with your life." She told us that 25 percent of transgender people commit suicide because they are so depressed and feel so hopeless.

Around that time Bruce considered traveling out of the country, possibly to Denmark, to have the gender-confirmation surgery and then come back to the U.S. identifying as female. I asked Bruce, "What about the children?" He thought maybe he could reenter their lives as "Aunt Heather."

As devastated as I was, my heart bled for Bruce and what he must have lived with his entire life. It's impossible for those of us who are comfortable living in our own skin to fully grasp what an imprisonment that must feel like to be born into the wrong body. I know it's difficult to understand, to emotionally or even intelligently wrap your head around. It was extremely difficult for me to comprehend, and adjust my life accordingly to, the realization that the man I had married -- the very masculine, gorgeous, ideal, wonderful hunk of a man -- would be no more. The human entity was still alive, but it truly was like mourning the death of the person I had grown to know and love.

Bruce and I separated after going to therapy for about six months -- just to exhaust any hope of keeping our family together. Being married to a woman was not what I had envisioned for my life.

I was so heartbroken that I would get in my car day and night and aimlessly drive up and down Pacific Coast Highway, crying. I mourned the death of my marriage, my man, and my dream of enjoying a lifetime of family togetherness. But I was also empathetic to, and mourned for, the pain that Bruce had experienced every day of his life. As earth-shattering as his confession had been for me, pulling the proverbial rug out from under my world, Bruce's struggle made mine pale in comparison. I now had to "man up," support Bruce and his decisions regarding his own body, take care of my sons, and move on with my life.

Bruce went to see a Dr. O'Dea and began taking female hormones. Thirty years ago the only hair removal that was permanent was electrolysis. There were no laser hair removal places then, as far as I know. Poor Bruce began the process of having electrolysis performed on his heavily bearded face. He then began having the hair on his chest removed. One excruciatingly painful hair at a time was targeted by an electrical current. Unimaginable. Bruce began to grow breasts as a result of the female hormones he was injecting. My life, my psyche, my femininity, my sexuality, my sanity was in a state of upheaval. I panicked about what I would ever tell my two boys about their former Olympian father, and how I would raise them alone. And then I would experience waves of crippling sorrow, not only for myself and my sons but for Bruce.

Human Rights Complaint 034 to UN

I may be the only woman in the state of California to have waived child support and alimony. But when Bruce and I divorced, that's what I did. As confused and sad as I was, Bruce was also very confused and extremely distraught. Again, Dr. Hill had told me that one in four transgender people commits suicide. I knew I didn't want that to happen. I had an open-door policy for Bruce when it came to visitation, letting him see his sons any time he wanted to. Brandon and Brody went over to his home occasionally but never spent the night there.

One day, after having spent a little time at Bruce's house, both boys came into the kitchen and said to me, "Mommy, we saw Daddy getting out of the shower naked, and Daddy has boobs!" That day I began trying to cover for Bruce, trying to protect him and trying to explain away what was clearly happening to his visage. I said, "Well, boys, you know how your dad was super-muscular and trained very hard for the Olympics? He had big muscles, and some of those muscles are called 'pectorals.' When you stop training and you stop lifting weights, sometimes the muscle turns to fat. So his pectoral muscles have probably just gotten a little flabby and look like boobs." I was trying to shield Brandon and Brody from the truth and protect Bruce at the same time. It was exhausting.

I began dating David Foster, whom I subsequently married a few years later. Bruce dated several women, even though he had begun his transition and showed signs of it. He had no facial hair, no chest hair, and boobs, and he had gotten a nose job and trimmed his Adam's apple. Clearly he was still confused and conflicted as to how fully he was ready to commit to changing his life completely.

If Bruce had told me about his gender issue when we first began getting romantically involved, I would not have married him. Pure and simple. But looking back, I'm so grateful to God, the universe, and Bruce that I didn't know, and that Bruce played the role in my life that he did. What a tragedy that truth, if Bruce had confessed it in 1979, would have been for my existence as I have known it! I would never have experienced the joy, the honor, the privilege of being the mother of the two most precious gifts I have ever known, Brandon and Brody. As life has a way of unfolding as it is meant to, I have learned to trust life.

I felt such a reverent obligation to keep Bruce's gender dysphoria a secret for Bruce to reveal or not that I did not even tell my sons until they were 31 and 29 years old, respectively. I wanted Brandon and Brody to experience enough life and garner enough knowledge, confidence, and compassion to be able to deal with their father's true self. We are not defined by our parents, but we don't know that as young children. I tried to raise my sons to embrace open hearts, forgiveness, kindness, tolerance, and compassion. They have been imbued with good values and are remarkably noble, showing incredible acceptance, understanding, and forgiveness toward Bruce and others.



* * * * *

I wouldn't be completely forthcoming if I didn't disclose in this writing that after Bruce and Kris married, there were periods of several years going by without Bruce attempting to contact or visit his sons. No birthday cards or

Human Rights Complaint 034 to UN

phone calls, no "Merry Christmas," no "Everything OK?" after the big Northridge earthquake. Brandon and Brody will never have those "Hallmark memories" of father-and-son moments. They were saddened by his lack of participation in their lives, and my heart ached for them. When Brandon asked me, "Mom, what kind of a father doesn't come to his son's graduation?" I meekly replied, "Honey, your dad may have been the world's greatest athlete physically, but emotionally, you have to view him in a wheelchair. If he had emotional legs, he'd get up and walk to you, but he just doesn't right now. Just try to understand him, love and forgive him." It was an analogy that seemed to soften the blow at the time, and I do believe that forgiveness is a gift we give ourselves; it's really not even for the person we choose to forgive but for us. We only do harm to ourselves when we harbor resentment and vitriol toward another. I do believe that everything is forgivable; some things are inexcusable but forgivable.

After Brandon and Brody were grown and I did reveal their father's issue, I think the knowledge helped them put the pieces together and explain some of Bruce's dysfunctional parenting. I certainly did my share of rationalizing through it all.

* * * * *

After having harbored his secret, and feeling in my heart and mind that I have protected him through these years, I can now breathe a little easier, knowing he now has found the strength and the courage to fulfill his dream. He can finally realize his need to be who he authentically is, who he was born to be. That takes tremendous courage. For that I commend him.

Bruce has already "gone through the fire," suffered unfathomable discomfort and pain, been held prisoner in his own flesh. It is certainly not our place to judge him or others who may feel trapped, ostracized, or alone.

My hope and my prayer is that humanity has evolved enough and been properly educated to exercise kindness toward those who have struggled or who we may perceive to be "different." Our uniqueness, our individuality, and our life experience molds us into fascinating beings. I hope we can embrace that. I pray we may all challenge ourselves to delve into the deepest resources of our hearts to cultivate an atmosphere of understanding, acceptance, tolerance, and compassion. We are all in this life together.

As Henry James so wisely advised, the three most important things in life are:

1. Be kind.
2. Be kind.
3. Be kind.

Appendix B English Culture as a barrier to Trans Healthcare

B.1 Medical culture barriers to giving transsexuals competent medical care

B.2 English Culture Barriers to Provision of Healthcare for Trans Chapter 8 Simona Giordano

B.3 English Culture Barriers to Government Funding of Healthcare for Trans Chapter 9 Simona Giordano

B.4 The Lancet - Insight - News - Is change possible?

B.5 The Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey (Youth'12)

B.6 Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada

B.1 Medical culture barriers to giving transsexuals competent medical care

from Principles of Transgender Medicine and Surgery

Introduction

Randi Ettner (Psychologist)

There are few medical texts, save perhaps some in psychiatry, that require the reader to reflect on social, legal, emotional, historical, biological, and economic matters when addressing patient care. The book in hand beseeches the reader to do precisely this.

The provider who purports to offer care to gender-variant individuals must forswear nearly every timeworn sacred canon of allopathic Western medicine. For example, a contemporary medical text urges the practitioner to depend on physical examination, laboratory tests, and newer imaging techniques as reliable tools to generate hypotheses about groups of symptoms and signs of disordered function, as they relate to one another by means of anatomic, physiologic, or biochemical peculiarity.

But this essential materialistic paradigm (a paradigm based on the doctrine that physical matter is the only discernible reality, and that everything else—thought, feeling, and will—can be explained only in terms of matter) fails to be serviceable when confronting a condition that belies these assumptions, which does not "reside" in the corporeal body.

Paradigms and systems of classification dissolve when one interacts with a gender-variant child or adult. There is no observable disease, there is no diagnostic test, and there is no organ deficiency. What there is, is a person who longs for a more authentic life experience and, oddly, must seek assistance from the most unlikely accessory—a medical practitioner.

Perhaps a more appropriate model for such care would be the ancient shamanic tradition of soul retrieval. In this model, the healer enters a nonordinary reality to search for the lost or stolen soul part. Upon finding it, the shaman entreats it to come home and returns it to the wounded person, who lies in waiting.

Those who work with gender-variant individuals must suspend judgment and protocols. Instead, like the shaman, they must offer help and support for wholeness and authentic identity—a modern-day version of the ritual and community that welcomed the returning soul part home.

The authors you are about to read eschew pathologizing positions. Each has emerged as an expert based on years of listening and hearing witness to narratives of those who long for identity alignment. Ironically, it is the regression to this fundamental mode of communication—listening—and the most evolved level of consciousness—compassion—that trump technology in advancing this burgeoning field.

My co-editors, Stan Monstrey and Evan Eyler, have provided valuable time, energy, and expertise in the creation of this book. As you read it, you will encounter a complete compendium of all aspects of medical and health care, as it exists today, to meet the needs of gender clients. We hope you will discover a tapestry of art and science as rich and mosaic as the lives of those who have shared their journeys with us.

WARNING:

This article is from USA. I don't believe that the following statement in the article below is correct in NZ or USA:
While we can be optimistic that such prejudices no longer plague the medical profession.....

Review

Barriers to quality health care for the transgender population

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a b s t r a c t

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The transgender community is arguably the most marginalized and underserved population in medicine. A special issue focusing on men's health would be incomplete without mention of this vulnerable population, which includes those transitioning to and from the male gender. Transgender patients face many barriers in their access to healthcare including historical stigmatization, both structural and financial barriers, and even a lack of healthcare provider experience in treating this unique population. Historical stigmatization fosters a reluctance to disclose gender identity, which can have dire consequences for long-term outcomes due to a lack of appropriate medical history including transition-related care. Even if a patient is willing to disclose their gender identity and transition history, structural barriers in current healthcare settings lack the mechanisms necessary to collect and track this information. Moreover, healthcare providers acknowledge that information is lacking regarding the unique needs and long-term outcomes for transgender patients, which contributes to the inability to provide appropriate care. All of these barriers must be recognized and addressed in order to elevate the quality of healthcare delivered to the transgender community to a level commensurate with the general population. Overcoming these barriers will require redefinition of our current system such that the care a patient receives is not exclusively linked to their sex but also considers gender identity.

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Introduction

Over the past decade the visibility of the transgender (trans) community has been steadily increasing due, at least in part, to representation in pop culture and the media. Nonetheless, while public awareness of trans issues has been heightened, clinicians, public health researchers, and officials are becoming increasingly aware that trans persons represent one of the most marginalized and underserved populations in medicine.

In fact, both the trans community and healthcare providers agree that there are many barriers to healthcare for trans persons that cluster around four main issues: (1) reluctance to disclose, (2) lack of provider experience and resources, (3) structural barriers, and (4) financial barriers [1,2]. This review will focus on these critical issues that create most barriers to care for trans patients as well as potential ways in which they can be addressed. Unfortunately, trans persons are frequently reluctant to disclose gender identity even when receiving medical care because of social stigma and cultural prejudices. While we can be optimistic that such prejudices no longer plague the medical profession the level of proficiency of health care providers in caring for trans patients is very limited [2]. Similar to lesbian and gay populations, trans patients have unique healthcare issues and needs that are often not recognized and a lack of education, training, and resources for providers compounds the problem [3–6]. Lastly, even when gender identity is disclosed to a well-versed and caring provider both financial and structural barriers still exist [7]. It is important that the quality of healthcare delivered to this very vulnerable population is discussed openly so that solutions that can elevate it to equality with other populations can be identified.

It is important to understand that the terms “sex” and “gender”, while often used interchangeably, have specific medical and psychological meanings. “Sex” commonly refers to physical characteristics whereas “gender” represents identity and self-image [8,9]. Trans persons experience their gender as being different from the sex that was assigned to them at birth, otherwise referred to as gender nonconformity [1]. Gender dysphoria refers to the distress that can arise from gender nonconformity [10,11]. For some, gender dysphoria may meet criteria for a formal diagnosis that might be classified as a mental disorder. In the DSM-5 these criteria include a strong desire to be treated and identified as the expressed gender, which results in an increased risk of distress leading to significant social and/or occupational impairment [12].

Formal epidemiological studies on the incidence and prevalence of gender nonconformity have not been conducted due to the enormous difficulty of achieving realistic estimates. Over the last several decades, studies from numerous countries have published prevalence data ranging from 1:11,900 to 1:45,000 for male-to-female (MTF) trans persons and 1:30,400 to 1:200,000 for female-to-male (FTM) trans persons [8]. However, these numbers should be considered minimum estimates at best as they are derived from clinics where patients met criteria for severe gender dysphoria and had access to care.

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B.2 English Culture Barriers to Provision of Healthcare for Trans Chapter 8

Simona Giordano

Children with Gender Identity Disorder

A Clinical, Ethical, and Legal Analysis

Simona Giordano

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8 Epistemological Issues Relating to Transgenderism

1 INTRODUCTION

We are in Lucania, in the south of Italy. Lucania (now called Basilicata) is historically one of the poorest and most forgotten areas of Italy. Carlo Levi, a Jewish doctor from Turin, is confined here in 1935. He discovers a desolated land. Women are witches, and men are farmers who leave at dark to reach the fields, two- to four-hour walk from town, and get back at sunset, with no awareness, "like a tide".³ The villages are fragile, built in malarious bricks of clay, prone to disaster and collapse. In the baleful heat of the Lucanian summer, Levi begins to understand that there is a parallel dimension to the one he had known, a third way of being human.

In 1945 Levi publishes *Christ Stopped at Eboli*. In the language of the southern Italians, being a Christian simply means *being a man*. As the epigraph to the chapter illustrates, the people at the time did not consider themselves to be *human*, because they were outside the borders of humankind. People from Lucania, albeit formally Italian, do not have political conscience: they are neither citizens nor contesters, neither fascists nor partisans, neither conationals nor enemies, they are just *beyond the state*. They are not *Christians*, they are *frusculicchi*: they live in a third unrecognised dimension; they are inhabitants of no man's land.

This is how the 'third sex' is sometimes described: as a no man's land.⁴ The very word 'trans-sexual', as we saw earlier in this book, was only coined recently, whereas the phenomenon of crossing genders has, of course, always been a part of human histories in virtually all cultures (although the social—and legal—response to it has been markedly varied). We have also seen that the term that is supposed to best capture the condition of gender minorities is widely disputed: any term seems to cloud the rich diversity in which gender can develop (see Chapter 1).

Epistemological Issues Relating to Transgenderism 141

The history of transsexualism raises many important sociological and ethical issues relating to the legitimisation of minorities, to the sensibility of the very concepts of sex and gender used in medicine and at law, and to many others. In this chapter I discuss some fundamental epistemological issues around gender identity development as, unless there are sound reasons to consider gender variance as a mental illness, its inclusion in psychiatric diagnostic manuals risks being not only a conceptual mistake, but also a moral wrong done to those affected.

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In January 2010 the Council of Europe stressed that considering gender variance as a mental illness may contradict the statement, as contained in the Universal Declaration of Human Rights, that "all human beings are born free and equal in dignity and rights",⁵ and on 23 June 2011 the council launched the report *Combating Discrimination on Grounds of Sexual Orientation or Gender Identity—Council of Europe Standards*, stressing the need to protect the human rights of lesbian, gay, bisexual, and trans-gender people across Europe. Just before then, on 17 June 2011, the United Nations Human Rights Council adopted a resolution which expresses concerns about violence and discrimination against people because of their sex and gender orientation.⁶ The World Professional Association for Transgender Health (WPATH) released a statement in May 2010 "urging the de-psychopathologization of gender conformity worldwide [. . . the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally-diverse human phenomenon [that] should not be judged as inherently pathological or negative".⁷ Gender identity is one of the most important, intimate, and private aspects of who we are. Gender identity like sexual orientation, concerns nobody else except for the person him/herself.⁸ Considering gender diversity as a mental disorder may be, to use Marcuse's epithet, a form of "repressive tolerance".⁹

2 WHY 'GID' IS CONSIDERED A MENTAL ILLNESS

As we saw in Chapter 4, Gender Identity Disorder (GID) is classified as a psychiatric disorder. It is worth repeating here what the diagnostic criteria for GID are in the DSM-IV (the ICD has similar criteria—see Chapter 4):

There is evidence of strong and persistent cross-gender identification.

This cross-gender identification must not merely be a desire for any perceived cultural advantages of being the other sex.

There must also be evidence of persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex.

The individual must not have a concurrent physical intersex condition.

There must be evidence of clinically significant distress or impairment in social, occupational, or other important areas of functioning.¹⁰

142 *Children with Gender Identity Disorder*

Whereas the psychiatric diagnosis has apparent advantages (some of these will be discussed later in this chapter), it also has potential psychological and social adverse implications.¹¹ It is therefore important to assess whether gender variance is appropriately conceptualised as a mental disorder, and, if not, what the normative implications of this are.

I consider in particular three main epistemological reasons for enclosing gender variance among mental disorders:

The first is that gender variance is associated with extreme psychological/emotional distress and with impairment in social and occupational or other important areas of functioning (see Section 2).¹²

The second is that no single somatic cause or set of causes has been found, which may explain the discomfort (see Section 3)—the implication being that thus the condition must be psychological in nature.

The third is that gender variance is perhaps not a *mental* disorder, but is nonetheless a disorder or illness as it is a marked deviance from a norm, where the norm in this case is defined in terms of "normal species functioning" (see Section 4).¹³

I select these arguments because they form a part of the main assumptions implicitly or explicitly accepted by a part of the scholarly literature on gender variance (see the following).

It should be noted that I am not in this way proposing a definition of mental illness, nor am I evaluating whether any of these epistemological reasons is a sufficient or a necessary condition to consider any given human experience as a mental illness. Moreover, for the purposes of this chapter, I assume that there is such a thing as a mental illness/mental disorder, without discussing the epistemological issues relating to these very notions." I rely on the characterisation of mental disorder proposed, for example, by the DSM.¹⁵ Central to it is the presence of a psychological or behavioural pattern associated with distress, which is not a part of normal development or culture,¹⁶ and which involves "clinically significant distress or impairment in social, occupational, or other important areas of functioning" (the so called clinical

significance criterion).¹⁷ It is worth stressing, however, that many have contested that there is such a thing as a 'mental' illness, and it is only for the purposes of this argument that it is presumed in this chapter that the notion has any meaning at all.

3 GENDER MINORITIES, SUFFERING, AND PSYCHOSOCIAL FUNCTIONING

Gender variance is invariably connected with suffering and it alters social adjustment and functioning: typically the individual and the significant others are profoundly affected by the discovery that gender identification is

Epistemological Issues Relating to Transgenderism 143

not the one they expected.¹⁸ Gender variance also alters the person's ability to function socially and is often associated with poor psychological and social outcome especially when proper medical care is not provided in a timely manner.¹⁹

Contrary to what may appear, these are not appropriate grounds for conceptualising gender variance as a mental disorder, for at least two reasons.

First, many conditions are associated with suffering and significant impairments in the life of the individual and the family. Breaking up, bereavement, and many other events may have similar consequences, but are not for that reason *mental illnesses*. Either it is accepted that, in fairness, many more conditions should be included in psychiatric manuals or it must be accepted that that ground may be shaky.

One may object that perhaps suffering and impairment in psychosocial functioning are not *per se* grounds to consider a condition as a psychiatric condition. However, the presence of distress and the adverse psychosocial sequelae may perhaps be *an indication* of a mental disorder, depending on circumstances and scales of the problem. For example, bereavement may cause extreme distress and psychosocial dysfunction. But if I am unable to work and function socially because my cat died a year ago, my bereavement may be an indication of a disorder of mind, even if, *per se*, bereavement is not a mental disorder.

On this ground, gender variance should be regarded as a mental disorder depending on the modality in which the individual reacts to his or her gender identification. This, apparently, seems to be what happens in clinical practice: if an individual has *some kind of* gender dysphoria, s/he is not for that reason diagnosed as having a mental disorder. The diagnosis is only attached to severe, persistent discomfort associated with negative psycho-social sequelae.

However, this objection is question begging: persistent and severe gender dysphoria is still regarded as a mental disorder, and this is precisely what needs to be justified. The problem, from a conceptual point of view, is why me not feeling the congruence between my body and my identity is regarded as psychopathological; of course, to respond that having a mild discomfort is not psychopathological does not answer the question.

Second, and perhaps more importantly, distress may be an *adequate* response to adversities. The example of bereavement fits well in this context. If I am no longer able to work and function in the same way I used to, because my son, rather than my cat, has died, my response may be adequate to the circumstances. What is an *adequate* response to events is, of course, open to debate, and there are significant grey areas of uncertainty. Some may say, for example, that even if I lose my child at some point in the future I should be able to 'recover' and resume a seemingly 'normal' life; others may argue that this would be impossible and that I could never be expected to live as normal in those circumstances; others may argue that perhaps the age of the child may make a difference: should I lose my

144 *Children with Gender Identity Disorder*

newborn baby the trauma may not be as profound as losing my ten-year-old son . . . and so on . . . Evaluating people's responses to adverse events obviously encounters endless conceptual and ethical problems. What this shows, however, is important and relevant to the understanding of what happens to gender minorities: it is not distress or psychosocial dysfunction *per se* that reveal the existence of a problem in someone's emotional or psychological life. A much larger perspective must be adopted in order to evaluate the adequacy of someone's distress as a response to any particular event in any given context.

Human Rights Complaint 034 to UN

In the case of gender minorities, distress may be an understandable (and perhaps adequate) response to adverse social variables and to a hostile environment. If my five-year-old boy insists on buying pink trainers with sparkles and consequently he is ridiculed at school by his peers, his upset and secrecy would be appropriate responses to the circumstances. Of course, we would all expect children to mix up and enjoy their childhood and be happy. But we know that stereotypes (sometimes rigidly internalised by children) may prevent acceptance of diversity. Thus the 'psychosocial dysfunction' rather than being the indication of an intrapsychic problem, may reveal a problem in the social context in which the individual happens to live. In fact, the ill psychosocial adjustment typically associated with gender variance seems to be, to a significant extent, a function of societal inability to embrace gender differences as normal (and nonpathological) and treat them as such (see earlier in this book). The Council of Europe has emphasised with great concern the high degrees of discrimination, abuse, and violence to which LGBTs are subjected.²⁰ Even in the absence of physical or verbal abuse, the marginalisation of the gender minority is apparent: marriage, employment, and many legal rights are often a function of 'gender'. Birth itself is marked by gender predictions and those who do not fit a mainstream gender divide are left in a legal and social vacuum.²²

Some people with gender dysphoria narrate the grief associated with having to continually pretend to be someone they are not, being scared of being caught or uncovered. They tell of secretly sneaking into their sibling's room to wear their clothes and about the relief of those minutes in which one could finally pretend to be him/herself. People are secretive and ashamed about how they feel. Being frightened of the response they might get, some people hide for many years and live in the grief of a continued lie to all others, often including their parents, partners, and children (see Chapter 4 for narrations). The intra-psychic suffering, thus, is inextricably intertwined with the moral and cultural imperatives accepted or internalised by the society in which the sufferer happens to live.

To describe gender minorities as suffering from a mental disorder because they lack serene psychosocial adjustment is to condemn them to a double jeopardy: they do not have the possibility of serene psychological and social adjustment because the existence of a normal, nonpathological 'different'

Epistemological Issues Relating to Transgenderism 145

way of being is not accommodated, and then they are regarded as mentally ill because they have not adjusted well.

4 GENDER DYSPHORIA HAS NO CAUSE

The hypothesis that gender variance may be caused by some physical disorder has attracted much attention in scientific settings: finding a somatic cause of gender dysphoria would have, at least apparently, a number of advantages. It would allow removal of GID from psychiatric manuals and inclusion in, for example, endocrinological manuals (with the consequent reduction of stigma associated with the psychiatric diagnosis). At the same time, it would apparently strengthen people's entitlement to publicly funded medical treatment or to reimbursement under insurance schemes.

The first candidates for the search for 'natural error' have been genes and chromosomes. Extensive research has been performed on the relationship between gender variance and endocrinological disorders such as disorders of sex development (DSDs) or intersex conditions. These conditions affect the development of primary and secondary sex characteristics. As mentioned earlier in the book, research has shown that, although there is a higher prevalence of gender variance amongst people with DSDs than in the 'normal' population, DSDs are not always associated with gender variance.²³ Gender variance is a different condition and often unrelated to DSDs, and DSDs are not the cause of gender variance.²⁴

It could be argued that in absence of a physiological explanation to gender variance, the condition must be psychological in nature. This is an argument that, implicitly or explicitly, recurs both in common discourse and in the literature on gender dysphoria.²⁵ As Raymond also points out, the term *psychiatric syndrome*, used to refer to the condition, "probably indicates that transsexualism [is not considered] to be of biological origin".²⁶

There are a number of flaws in these types of assertions.

First, *prima facie*, the absence of a somatic cause is arguably an indication that there is no pathology rather than that there is psychopathology,²⁷ even in the presence of distress.

Human Rights Complaint 034 to UN

Second, the very notion of mental illness is contentious, and, if used to denote situations of distress that are unexplained by somatic factors, risks becoming the collection box of experiences and behaviours that are difficult to understand. This could have wider implications: for example, the psychiatric diagnosis may become an instrument of social control,²⁸ and it may detract attention from the relational or social causes of distress.

Third, this argument implies that body and mind are two ontologically separate entities. Gilbert Ryle spoke about this 'Cartesian' belief

146 *Children with Gender Identity Disorder*

as a myth, a dogma,²⁹ which is as largely accepted as it is philosophically or scientifically unproven.³⁰

Fourth, the fact that the causes of gender variance are unknown does not mean that they do not exist. It is possible that research development will identify some somatic causes for gender variance, and that gender identity development will be understood better at some point.

Finally, there is an important point to note. The causes of atypical gender identification are unknown. Likewise, the causes of *typical gender identification* also are. The hypothesis that gender develops 'quite naturally' based on our genetic and chromosomal endowment is a mistake. The basic biological facts (determination of sex) are not straightforward (see also Chapters 2 and 3).³¹ Even considering the basic biological facts, there is no clear 'order' to which one may refer in order to determine the 'disorder'.

The construction of gender, the adoption of gender roles, and the adaptation to gender expectations are determined by biological and social forces, which interact in a somewhat mysterious way to shape who each of us is. There are various theories of gender development, as discussed earlier. Yet, ultimately, how genes, social stressors, and historical and cultural variables interact to make each of us into the 'gendered' individuals we are is unknown. How gender identity develops is an open question both in 'atypical' and in 'typical' cases, as discussed in Chapter 3. This seems to imply that there is no clear set of biological or social markers to which one could cling to determine which gender developments are 'normal' and which are 'pathological'.

The belief that, in nature, there are men and women, or that those who do not fit the divide are *disordered*, is thus a superstition, and it is no less of a superstition than the belief that there are *frusculicchi* or that your future is written in the lines of your hand.

The claim that some types of gender development are *disordered*, thus, seems to mean that they *deviate* from what happens to the majority of people. I will deal with this argument in the next section.

5 GENDER AS VARIATION FROM NORMAL SPECIES FUNCTIONING

It could be argued that maybe gender development is not yet understood; however, without a doubt in the vast majority of cases gender development does not cause the distress we see in children with atypical gender. Most people grow in the gender assigned to them at birth, and do so quite comfortably. If some people do not develop in a similar way, then this fact in itself may be an indication that there is pathology. Add to this the fact that gender dysphoria is always marked by great confusion and distress, then one may reasonably conclude that there must be some kind of pathology, even if the aetiology is unknown.

Epistemological Issues Relating to Transgenderism 147

Of all the arguments examined so far, this is the most problematic, both from a conceptual and from an ethical point of view. The vexed question of 'what is a disability' has challenged philosophers and medical ethicists for some time. Indeed, sometimes 'illness' has been defined in terms of deviation from "normal species functioning". I will not repeat here the controversies surrounding the notions of disorder/illness/disability." What is important to note is that an illness, and thus also a *mental illness*, cannot simply be defined in terms of *variation from what happens in the vast majority of cases* (even if it is a variation associated with great distress). The vast majority of

Human Rights Complaint 034 to UN

people are right-handed, and yet being left-handed is not pathology. The majority of adults in Western countries perhaps are short-sighted, and yet having twenty-twenty vision is not for that reason an illness.

Being a part of a numerical difference is no indication of illness. To consider gender, which is a form of private and intimate difference, as 'mental illness' is not real acceptance of the difference as a fully legitimate fact, but willingness to endure it, on the condition that it is marked out as 'anomalous' and 'sick'. "This sort of tolerance" wrote Marcuse, is "repressive tolerance"; it "strengthens the tyranny of the majority".³⁴

"Majorities", said the poet De Andre, "have the bad habit to look over their shoulders, and to count, and to say 'we are six hundred millions, we are one billion and two hundred millions', and, taking advantage of being so numerous, they think they are able to, they are entitled to disturb, to humiliate, the minorities".

There are, of course, various ways to humiliate: verbal and physical abuse are only two of these. To condemn a minority to the stigma of mental illness with no sound reason is another way. It is true that distress is associated with gender variance: however, this distress is significantly a function of societal inability to embrace gender differences as normal, and in societies where the gender divide is not as marked, transsexuals suffer less." The stigma of the psychiatric diagnosis marks out this difference as a disorder, and thus risks reinforcing some of the very causes of distress.

6 PRAGMATIC REASONS TO RETAIN THE PSYCHIATRIC DIAGNOSIS

There may be other important reasons, which are not epistemological, for retaining the formal diagnosis of GID. For example, it has been argued that a formal diagnosis encourages research development,³⁷ that it helps make more reliable predictions and therefore avoid treating false positives: for instance, Wallien and Cohen-Kettenis suggest that children who meet the complete DSM-IV criteria for GID are more likely to be persisters.³⁸ Moreover, the psychiatric diagnosis provides a sort of (possibly reassuring) 'explanation' for seemingly inexplicable experiences; it can protect

148 *Children with Gender Identity Disorder*

both sufferer and the significant others from feelings of guilt and blame, which are often associated with 'abnormal' behaviours; perhaps more importantly, a formal diagnosis might facilitate access to NHS treatment or insurance coverage.

These reasons do not relate to *how we may understand gender variance*, or any other human experience, and in this sense are not epistemological in nature. They have to do with the *practical consequences* that retaining the diagnosis has for the people concerned, for their families, for the medical profession, and for society at large, but are not for this less important: if retaining the psychiatric diagnosis was highly likely to promote and protect people's welfare, this would provide a strong *prima facie* reason in its favour.

However these pragmatic reasons are not straightforward.

6.1 The Relationship between Diagnosis and Treatment

With regard to access to treatment, medical treatment for gender variance is complex and long lasting (see Chapter 5). One worry may be that removal of GID from psychiatric manuals could affect the sufferers' right to access medical treatment or to funded treatment. However, this is not necessarily the case. In the United Kingdom, for example, Primary Care Trusts (PCTs) make decisions on the matter depending on budget. In May 2010 breast surgery was refused to a transgender with the argument that this is 'cosmetic surgery'.³⁹ According to the Gender Research and Education Society 2009 Report," the NHS may fund the following treatment for male to female trans:

orchidectomy—removal of testicles

penectomy

vaginoplasty

clitoroplasty

hair removal—donor site

Mammoplasty (breast enlargement) thyroid chondroplasty (reduction of the Adam's apple), facial feminising (like reshaping of the nose and chin), body reshaping, cricothyroid approximation and other vocal surgery to raise the pitch of the voice, hair removal of the face and body, and hair transplant (to mitigate male baldness) are not typically funded publicly.

For female to male trans, the following are usually funded by the NHS:

mastectomy

hysterectomy

vaginectomy

salpingo-oophorectomy—removal of the fallopian tubes and ovaries

Epistemological Issues Relating to Transgenderism 149

metoidioplasty—creation of micro-penis using the clitoris

phalloplasty—creation of penis, with or without the urethra

urethroplasty—creation of urethra within the penis

scrotoplasty—creation of scrotum

placement of testicular prostheses

Not included are penile prosthesis, that is, an implant that makes erection possible, and hair removal (donor site). It is clear that the list of funded treatment is not inclusive of all procedures that are necessary to confirm one's gender. Therefore, there is a doubt that the psychiatric diagnosis can grant publicly funded healthcare interventions. Things may be even trickier in other countries, where the psychiatric diagnosis can become a boomerang. In the US, for example, insurance companies generally offer coverage only for 'psychiatric' treatment for diagnosed mental illnesses. Therefore, they may subsidise psychotropic drugs for depression and anxiety that may be associated with GID, but hormonal treatments and surgery, which may be needed by people with gender variance, might be excluded from insurance coverage.⁴¹ Therefore, the psychiatric diagnosis may be a boomerang: it may not help sufferers to obtain the medical care they may need, and it may instead reduce their chance to obtain the needed publicly funded treatment.

It should also be noted that, if the concern is access to medical treatment, there are alternatives to the psychiatric diagnosis. For example, in view of the similarities experienced by sufferers and of the significant numbers of people affected, one possibility would be to regard the condition as a *syndrome*. A syndrome is a cluster of experiences and phenomena that "run together",⁴² that are seen in association, whose aetiology is often unknown. These are not psychiatric conditions, and are not even regarded as illnesses, strictly speaking.

Even if whatever has to do with gender were demedicalised (like homosexuality and heterosexuality⁴³), this should have no bearing upon access to treatment. Medical treatment should be offered based on need and prognosis, not based on nosology or on the classification of the sort of condition one has. I will discuss this at greater length in Chapter 9, but let us anticipate some considerations here.

6.1.1 Medical Treatment Should Only Be Offered for Illnesses

It could be argued that doctors have a moral obligation (*prima facie*) to treat people's *illnesses*, and that they do not have a comparable obligation to satisfy people's *preferences*. For example, it may be appropriate to offer breast reconstruction after a mastectomy due to cancer, but it is not equally appropriate to offer breast reconstruction if I

Human Rights Complaint 034 to UN

want to look more feminine. You cannot claim a right to be cured if there is no illness to cure. Unless gender dysphoria is an illness, there is no right to medical treatment.

This argument rests on the idea that *medicine should only intervene to cure illnesses/disabilities*. As such, this argument is incomplete: it should be

150 *Children with Gender Identity Disorder*

grounded on a somehow clear view of what constitutes an illness/disability, and what 'normality' is. As suggested before (and as discussed at great length in Chapter 3), it is not clear what 'normal' and 'abnormal' stand for here. More generally, the notions of illness, disorder, and disability (and other synonymous) are highly elusive, and there is no consensus as to how they should be understood or defined. In fact, arguably, the definition of 'illness' is not a primarily medical issue, but is primarily an ontological issue relating to what sort of entities humans are, and on axiological categories relating to what each of us believes a good life to be. Some have, for example, argued that deafness is not an illness but a desirable attribute." This is because their axiological views differ from those of others: they believe that being unable to hear is a good thing, that it is better for some people overall to be deaf than to be hearing. For them, deafness is not an illness. This is just one illustration of how the definition of 'illness' cannot be provided by means of empirical observation: it is a matter of values, and of values over which consensus cannot necessarily be expected. The argument that medicine should only intervene to cure diseases or disabilities or illnesses thus is question begging, because one can ask what are the *illnesses or disabilities* which grant access to medical treatment, what is it that make some conditions *illnesses or disabilities*. Therefore, also the argument that people have a legitimate claim to medical treatment only insofar as they have a 'diagnosed' illness is at least incomplete.

There is another problem with the argument at stake here: it proposes an understanding of medicine that is too narrow.

6.1.2 A Too *Narrow Understanding of Medicine*

Intending medicine as an enterprise only aimed at curing diagnosed illnesses is too narrow a view of medicine, and one that is in contrast with the general understanding of what medicine is for. Many interventions are regarded as within the sphere of legitimate concerns of medicine, and yet do not repair illnesses, disabilities, or variations from normal functioning. On the contrary, often they *reverse* what appears to be 'normal functioning'. Earlier I made the examples of contraception and pain relief in labour. In both cases, there is no illness, no dysfunction, and what is happening is perfectly normal. Yet medical treatment is provided. The role of medicine is to improve people's quality of life, prevent harm, alleviate suffering (even suffering that is normally associated to a natural event). As also mentioned in Chapter 6, age related conditions are other examples of 'normal species functioning': it is 'normal' for postmenopausal woman to have reduced bone mineral density, yet medicine intervenes to 'treat' what is very normal species functioning, a very normal and spontaneous development, in order to prevent or alleviate suffering and improve quality of life. Another example is vasectomy: here a mutilation is performed, which reverts what appears perfectly 'normal' functioning in order to improve the person's quality of life. Countless examples similar to these could be provided.

Epistemological Issues Relating to Transgenderism 151

In these and many other cases, the NHS or insurance companies pay for these interventions. Treatment for age related conditions is funded in the UK and reimbursed within many insurance schemes. Surgery for birth marks or 'bat ears' can be publicly funded in the UK. Insurance companies might pay for purely cosmetic surgery in cases of, for example, breasts disparities occurring at birth or as a result of other illnesses such as breast cancer.⁴⁵ In these cases, there might not be any 'medical' necessity to have additional surgery, and yet this is offered to alleviate psychological suffering and enhance quality of life.

This illustrates how often medicine intervenes with medical treatments and surgery when there is no diagnosed 'illness', and even to revert what is 'normal functioning'.

To return to gender dysphoria, it is thus unclear why removal of GID from diagnostic manuals in principle should affect people's entitlement to receive medical treatment, to public support under the NHS, or to insurance coverage under privately funded schemes.

6.1.3 Society Might Be Wrong, but This Is Not a Reason to Deny Medical Treatment

As we have also seen in Chapter 6, it could be objected that in cases where the condition is social in nature, that is, caused primarily or exclusively by social variables that are clearly identifiable, those social factors must be amended, rather than people's bodies. On this line, it could be objected to the arguments I proposed so far that in cases of pain relief or contraception or reversal of age related conditions there is an undesirable physical state that medicine can ameliorate. In the case of gender dysphoria, people instead appear to suffer primarily because of mistaken social norms and policies. If society is wrong, we should not mutilate people's bodies: we should endeavour to change society. We have seen in Chapter 6 that sometimes this argument has been stretched to the extreme of arguing that cross sex surgery reinforces the stereotypes that cause gender dysphoria, and is therefore immoral both for the individual and for society as a whole.

This argument is, however, also flawed. People often suffer due to a variety of reasons, which are at times inextricable. Some of these reasons are inherent to their condition, and some might be social or familial. This should have no bearing upon access to treatment. Indeed, this has no bearing in other cases of healthcare provision. I have already partly answered this objection in Chapter 6, but let us further this point.

For example, not wanting children is often a matter of social and cultural variables. Yet contraceptive treatment is provided and not denied based on the fact that it is sought for social reasons. In Chapter 6 I mentioned the example of fertility treatment: this can be provided, and is often publicly funded, regardless of how people came to be infertile or why they suffer being childless.

152 Children with Gender Identity Disorder

If we identify the social causes of people's unhappiness, we have a reason to try and amend these; yet medical treatment is typically provided not on the basis of whether or to what extent biological rather than social factors contribute to the applicant's request. Medical treatment is provided if people suffer and treatment can benefit them. If medical intervention appears to be in the applicant's interests, then in principle it should be offered.

To deny medical treatment to those who are in distress partly because of social reasons is to inflict a double jeopardy on them: they suffer a social wrong, and, in addition to this, medicine, which could help, fails to assist. Social intervention, such as changes in the law and in some social policies, as well as public education, may indeed all be necessary to fully address the legitimate needs of gender minorities; these, however, do not exclude the fact that medical intervention may also be necessary.

6.1.4 Treatment Should Be Given If It Is in the Person's Interests

Endocrinologists might feel unease in giving hormonal therapies, especially to young minors, when they have no hormonal defects or illnesses. However, medicine should serve the interests of patients, not of doctors.

Confining the role of medicine to the cure of illnesses not only meets with insurmountable conceptual problems relating to the definition of illness and normality; it also defies the scope of medicine. Medicine intervenes with medical therapies in cases in which there is not, strictly speaking, 'medical' necessity (see Chapter 6). If medical treatment is to be withdrawn in cases of gender issues because gender issues do not qualify as illnesses, or because they are to an important extent the result of social factors, many of other medical treatments should consistently be withdrawn as a matter of fairness.

6.1.5 Where Do We Draw the Line?

The absence of a diagnosis should not in principle have a bearing upon the right to access medical treatment and the right to public funds and insurance coverage. The test to assess whether treatment should be provided is whether people suffer and whether medical treatment could alleviate their suffering. If suffering can be alleviated, there is a *prima facie* moral reason to do so, and stringent moral reasons should be provided to justify denying beneficial medical interventions.

One could ask whether, on my account, the state or insurance companies should also provide for 'cosmetic' surgery: people could be in extreme distress because they dislike some of their body parts.⁴⁶ Or, more provocatively, one could ask whether on my

Human Rights Complaint 034 to UN

account the state or insurance companies should also pay for recreational drugs to release the existential suffering of many young people on Friday nights.⁴⁷ I will return to these questions later in the book, but let's draw some indications of where this discourse may lead.

Epistemological Issues Relating to Transgenderism 153

My account leaves a question open, of where society should draw the line between interventions that are needed *enough* to be provided and paid for and interventions that are somehow unwarranted or even unethical.

However, it is not 'my account' that does so: there are two broader questions. One is of how scarce resources should be distributed and what areas of healthcare should receive priority; the other is which medical requests can ethically be satisfied (regardless of who should pay for them). Examples of controversial medical interventions are blepharoplasty for Asian women; nose filing for black people; and skin bleaching and similar, derogatively called 'racial' surgical interventions. These issues are on the ethics agenda: however, these go beyond the discourse of gender identity. Medical intervention for gender minorities should certainly not be suspended until these broader issues are resolved.

The fundamental point here is that *if* GID were to be removed from the diagnostic manuals (as it should), *this would not mean, ipso facto, that medical treatment is unwarranted*. Where we should draw the line is certainly a problem over which we (philosophers, policymakers, and the general public) should reflect more. In the next chapter I will consider whether treatment for gender minorities should fall on one side of the line or on the other, and why this may be so. I will do so by considering the arguments for and against provision of care for gender variance.

On the other hand, it is a mistake to think that leaving GID in the psychiatric manuals grants access to treatment. As we have seen, the psychiatric diagnosis can be a boomerang: it might mean that hormonal and surgical interventions are excluded from coverage.

7 THE RELATIONSHIP BETWEEN DIAGNOSIS AND RESEARCH

With regard to research, research on gender development was carried out long before GID became a diagnostic category. We have seen in Chapter 3 how Bowlby and Bandura, for example, performed groundbreaking experimental studies already in the 1950s and 1960s. We have seen that former philosophers, such as Comte, Mill, and others, proposed theories relating to how gender should develop and what this should imply (see Chapter 2). This happened a long time before the nomenclature of GID even existed. There is no reason why research should be negatively affected by the removal of GID from the diagnostic manuals.

With regard to the reliability of predictions, if the DSM criteria prove helpful in order to frame strategies of intervention, then they should be used. This, however, does not imply that the psychiatric diagnosis must also be retained. In principle, the criteria could be used to assess whether and at what stage to begin medical treatment, without necessarily having to result in a psychiatric diagnosis.

154 *Children with Gender Identity Disorder*

With regard to the reassuring potential of the psychiatric diagnosis, indeed the person may not know or understand what is 'going wrong' with her/him, and being told that what is happening is a recognised disorder, with a name and clinical features that recur in a similar way in other people, may soothe anxiety." But it is not clear why a sufferer and her/his family may not be equally reassured at hearing that gender variance is a normal way in which gender may develop; that there are many people similarly developing in an atypical way; that there is no pathology one should worry about; and that there is a wide range of medical, social, and lifestyle interventions that can help. It is unclear why a statement of normality should be less reassuring than a diagnosis of psychopathology.

Finally, there is something important to note with regard to the protection from guilt and blame. On the one hand, the diagnosis may help sufferers and families to tolerate what is happening; on the other hand, inclusion of GID in psychiatric manuals has not heralded greater social tolerance towards LBGTs. LBGTs remain one of the minorities most subjected to discrimination, abuse, violence, and murder.⁴⁹ The classification of gender variation as a mental illness can detract attention from the social forces that

Human Rights Complaint 034 to UN

are responsible for the person's suffering, by reinforcing the prejudice that the problems of transsexuals are intra-psychic, that they lay principally within the affected person, and that they are not relational or cultural in any decisive way.

Thus, even considering the practical implications of retaining the psychiatric diagnosis, it is not clear that, on balance, this serves the interests of those affected.

Gender identity is a part of who we are, and it results from a mysterious interplay of biological and social forces. Both typical and atypical gender identification are poorly understood, and there are no clear biological markers of sex and gender development which could suggest that one way of being is healthy and another is pathological.

Accepting the existence of a variety of ways of being woman or man means looking beyond the stereotypical gender divide and accepting that all people "are born equal in dignity and right" regardless of their sex and gender orientation, and that their difference should not be regarded as deviance.⁵⁰

In the absence of sound reasons, epistemological or otherwise, for retaining the psychiatric diagnosis of GID, the inclusion of gender variance amongst mental disorders, far from serving the interests of the people affected, may illustrate societal inability or unwillingness to recognise the full legitimacy of gender minorities and to consider atypical gender development as one of the different ways in which identity can be formed.

B.3 English Culture Barriers to Government Funding of Healthcare for Trans

Chapter 9 Simona Giordano

Children with Gender

Identity Disorder

A Clinical, Ethical, and Legal Analysis

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9 Should Gender Minorities Pay for Medical Treatment?

Ovla kon ascovi me gava palan ladi me gava palan bura of croiuti.

I will follow this migration, I will follow this current of wings.

(F. De Andre and I. Fossati, 'Khorakhane', 1996)¹

1 INTRODUCTION²

The inclusion of transgenderism among mental illnesses is contentious.' As we saw in the previous chapter, the Council of Europe, in January 2010, also stressed the need for recasting transsexualism in terms of individual and private difference, rather than as a mental disorder (see also the 2011 documents quoted in the previous chapter). Some commentators have pointed out that the classification of Gender Identity Disorder (GID) among mental illnesses is by all means peculiar, in that the 'treatment' for it is at odds with any plausible conception of 'treatment': 'treatments' are supposed to eliminate or reduce the symptoms, whereas in the case of gender dysphoria, medical treatment proposes to alter the body in order to match the very belief that is regarded as the main manifestation of the alleged mental illness.⁴ However, if GID were to be removed from diagnostic manuals, where would this leave people with gender dysphoria, in terms of access to medical care?' Should the state (or insurance companies) pay for medical treatment for gender issues?

2 METHODS

The methods used here are somewhat a departure from the typical methods of applied philosophy and from the methods used so far in this book. First, I ground this chapter on a thought experiment: the thought experiment is that GID is no longer officially regarded as pathology. Second, on this assumption, I construe two cases: one gestures towards the conclusion that, if it is accepted that gender issues are not pathology, then they should be treated in the same way as other types of body dissatisfaction: medical treatment should be negotiated by applicants and healthcare professionals, as in cases of 'cosmetic' surgery; the transaction is a private matter and medical treatment should be paid for privately by the applicant. In the other line of argument it is claimed that gender issues are often not comparable, in normatively relevant ways, to other types of body dissatisfaction, and that it would be unethical to refuse

Human Rights Complaint 034 to UN

funded medical treatment if that treatment is likely to prevent serious harm. Within each scenario, the arguments are explored with the classic methods of analytic philosophy: the morally relevant facts are identified, and the reasons for and against publicly funded or reimbursed care for gender issues are explored. Of course, it is possible to think about even more scenarios and arguments: those identified are possibly the most plausible that could be brought for and against publicly funded treatment for transgenderism.

In this way, I aim at illustrating some of the complexities relating to medical treatment for gender dysphoria and at showing how seemingly plausible arguments may prompt seemingly irreconcilable conclusions. I will not criticise each argument in turn, but, in running parallel scenarios, the arguments themselves will oppose one another, and the relative pitfalls of each contention will become apparent in the course of the chapter. I will in the end offer my resolution to the dilemma. I will argue that, in cases of gender identity issues, we have *prima facie* stringent moral reasons to offer funded medical treatment.

3 INSTRUCTIONS FOR CHAPTER USE

After reading the summary in Section 4, proceed to read scenario 1 and scenario 2. Both scenarios contain the same sections. When you move from one to the other, you may read the same arguments again, but they are presented in a way that leads to opposite conclusions. For reasons of simplicity, most references are only found in scenario 1. To make the reading somehow easier, I have labelled the sections in scenario 1 as S1.1, S.2, etc., and those in scenario 2 as S2.1, S2.2, and so on.

4 SLIDING DOORS: SUMMARY

Sliding Doors is a 1998 film directed by Peter Howitt, starring Gwyneth Paltrow. Here is a summary:

Helen is fired. She leaves her office to go back home. In the Underground her life is split. In one scenario, she gets on the train, and by chance she meets James, a charming man. But she gets home to find her partner in bed with his ex-girlfriend. She moves out, her life and career begin again, she meets James again, and in an accident, she dies. In the other scenario she misses the train, and, as she returns home later, she remains ignorant of the partner's affair. He does not work and she keeps supporting him with occasional jobs. . . eventually she meets the charming James. . . . The film runs through double railways, in a paradoxical time overlap.

In the fiction proposed here we also have two scenarios. In both scenarios GID is removed from diagnostic manuals: the human right to be different is upheld; it is claimed that people should not be discriminated against, subjected to any form of abuse and violence for reasons relating to their sex and

158 *Children with Gender Identity Disorder*

gender orientation; each individual should be free to explore and construct their identity, without for that reason having to pay the price of being called mentally ill, or the price of any other type of discrimination and abuse.

The difference between the two scenarios concerns what this personal freedom entails, and here the chapter splits. . . .

SLIDING DOORS

SCENARIO 1

S1.1 Felines, Star Treks, and Other Varieties: Should Doctors Do This?

People may be unhappy with some body parts: the fact itself is of no surprise. But sometimes, dissatisfaction may be extreme. Some people would rather not be human. The woman known as the 'Cat Woman' or the 'Cat Lady' underwent several interventions of facial surgery to look like a cat. She has had surgery on her eyes, which have been pulled up and back; she has had several silicone injections to her lips, cheeks, and chin, and a facelift in order for her face to look feline. The fiction *Star Trek* prompted another fashion: the application of silicon to look like the characters of the film. Various trends include 'sacrification' (skin cutting or marking), ear cutting and reshaping (generally to produce appearance similar to the elves), tongue splitting (to replicate the snake's tongue), and others.' People, of course, also seek what may appear to be more moderate interventions. For example, a growing number of Asian women seek blepharoplasty,⁸ and an increasing number of black women seek surgery to look more Caucasian.' Whereas these types of medical

Human Rights Complaint 034 to UN

interventions might seem less extreme than the ones reported before, they give rise to perhaps more acute ethical dilemmas, as they are based on 'suspect' norms of social acceptability. In some cases, these norms are inherently racist and are more worrying to the extent that they are internalised by the person belonging to the discriminated group. It could be argued that the medical profession, by providing medical treatment to people seeking 'racial' surgery," somehow contributes to the idea that, in order to be acceptable, a person must conform to a stated normative aesthetic standard, which is arguably racist.

Let's see what this all has to do with transsexualism and access to medical treatment.

S1.2 The Case of Gender Identity

Ethically, those interventions that seek to amend ethnic features, as well as many so called 'cosmetic' types of surgery, such as breast implants, liposuction, and so on, may be even more problematic than a (more unconventional and perhaps more 'autonomous' or personal) preference to look like Mr. Spock. They in fact appear to induce people to conform to (or reveal the way in which people internalise) stated standards of social acceptability, which are suspect or even openly racist.

Should Gender Minorities Pay for Medical Treatment? 159

SCENARIO 1 (continued)

Not dissimilarly to many of those seeking 'cosmetic' and 'racial' surgery, people with gender dysphoria also appear to suffer because of 'suspect' norms of social acceptability. In many Western societies it is assumed that people should be either men or women. The binary model of gender does not represent the many ways in which gender may develop.¹²

In societies where the gender divide is not as marked, as we have discussed earlier in the book, transgender people suffer less." Trans often report that a significant portion of their suffering relates to the disillusion of expectations that the significant others, initially often their parents, construct around their gender.

Gender dysphoria is in an important way a function of societal inability to contemplate alternative representations of one's identity:¹⁴ it is thus *on a par* with other types of body dissatisfaction caused by suspect norms of social acceptability. These norms, in the some cases, are clearly morally discriminatory and racist. In the case of gender, they are not only morally dubious (they in fact condemn those with atypical gender identification to the corner of 'deviance'); they are also conceptually mistaken, as we are now going to see.

S1.3 Gender as a Social Construct

The idea that there are only two genders, fixed and stable across one's life, is a mistake: the binomial distinction of gender does not capture the diversity in which gender may develop; it also assumes that normality requires sex and gender to be congruent, and thus conjectures that biological sex is a clear datum, observable by means of empirical inspection. Under this perspective, an XX individual with primary and secondary sex characteristics congruent with genetic and chromosomal heritage (a biological female) who does not identify with the biological sex, suffers gender dysphoria. However, the biological facts are not straightforward, as we saw in Chapter 2. If biological sex was truly the standard test to assess normality, then those with DSDs should always be confused about their gender, and this is not the case. Many intersex individuals have unequivocal gender identification. Many of those with atypical gender, reversibly, often have no identifiable DSD.

Gender is, to a large extent at least, a social construct. Gender is in an important way construed around the cues (positive and negative reinforcements) provided by the significant others at a developmental stage (see Chapter 2). This has important ethical implications for medical practice.

S1.4 Ethical Implications for Medicine

If the primary cause of people's suffering is the set of unrealistic stereotypes around sex and gender, it follows that medicine should be wary of reinforcing models of 'normality' or 'acceptability' that are responsible for tribulation. Agencies with an important social influence (such as the NHS) have a responsibility not to reinforce potentially dangerous prototypes. The case of the media and anorexia nervosa is a glaring illustration of this liability: the

160 *Children with Gender Identity Disorder*

SCENARIO 1 (continued)

British Medical Association (BMA) has suggested that the use of very thin models may trigger anorexia in young women, and has warned the media and the fashion industry to exhibit more realistic images of the female body;¹⁵ in some jurisdictions, emaciated models have even been banned from the catwalks.¹⁶ The argument is that if models of unrealistic beauty are dangerous, there is a reason not to use them. Why shouldn't the medical profession be subjected to the same norms of moral responsibility?

The effort in the direction of dignity for all, in spite of personal arbitrary differences (such as body shape, age, and gender) should be a concerted effort by all those with public influence over people's welfare. Therefore, certainly the state should not give its support to practices that are ethically dubious and that risk reinforcing discrimination against those who are different.

If suffering is caused primarily by suspect norms, then the state should not provide support to medical practices that, implicitly, contribute to crystallising those norms. Instead, the state and civil society should attempt to change suspect norms rather than people's bodies.

S1.5 A Matter of Private Transaction?

It could be objected that even if some conditions are primarily social in nature, this does not mean that medical treatment should be denied: first, it is not always clear to what extent suffering is caused by social factors; personal variables, intra-psychic factors, even unknown biological influences may also be implicated in any disease. It cannot be up to doctors to make judgments over the authenticity of one's requests.¹⁷ Second, all our preferences or needs are somehow influenced by society and the environment, and it is customary for medicine to intervene despite this. Infertility treatments, surgery for bat ears, and breast reconstruction following cancer treatment are only a few examples of medical interventions provided largely because of social stereotypes of 'normality': they are administered purely on psychological grounds and are often publicly funded or reimbursed under insurance schemes (see Chapter 8).¹⁸ Denying treatments for socially determined suffering would lead to a whole recasting of medicine." Third, it could be objected that whereas influential agencies have a responsibility not to spread dangerous ideals of social acceptability, individuals should not be turned into martyrs of ideals:²⁰ if I request skin bleaching because I experience being black as disadvantageous, it is of little help to me to be denied the treatment that would improve the quality of my life, in the name of ideals of equality or nondiscrimination in which I do not recognise myself.

For these reasons, provision of these treatments is not unethical, but it must remain within the arena of private transactions between applicants and professionals. Competent adults have significant freedom to decide what they want to do with their bodies and with their private lives: over these matters

Should Gender Minorities Pay for Medical Treatment? 161

SCENARIO 1 (continued)

they have a *prima facie* right to absolute noninterference. Decisions relating to one's body, within the limits of duty of care and professional responsibility, should be matters relating to personal freedom and should be treated as private transactions between applicants and professionals.

S1.6 "All People Are Free in Dignity and Rights"...

... recites the *Universal Declaration of Human Rights*.²¹ Thus, people with similar problems should be treated similarly. To fund treatment for gender issues at the expense of equally valid claims is an infringement of this important principle of ethics: not only would this imply that those other claims are less worthy of attention; it would also insinuate that people with gender dysphoria are *a case apart*. Rather than protecting and defending transgender people from discrimination and stigma, a default policy that provides publicly funded treatment for transsexualism but not for other requests of body modification reinforces the label of transsexualism as an illness, a deviance.

Human Rights Complaint 034 to UN

All desires to look more 'like oneself', to feel better in one's skin, are on a *par*: they are either all paid for or none are paid for. If only some can be paid for, then they should be chosen at random, or based on income, or on some other morally neutral criteria. Distribution in these cases should not be based on a fictional 'clinical' need, as becoming feline may be as important to the Cat Woman as a breast implant to a transsexual.

Moreover, one should ask: what are 'gender' issues? The answer to this question is not straightforward and this illustrates further how it would be unethical to publicly fund sex realignment treatment but not other body modifications.

Suppose I suffer because I have an androgynous structure: my perceived gender, my sense of who I am collides with the way I look. Mine is, of course, an issue of mismatch between my external phenotypical appearance and who I feel I am. Why should I pay for hair removal and breast implants, which relieves my mismatch, whereas females who want a penis should not pay to correct their own mismatch?

S1.7 Conclusions

The classification of gender dysphoria amongst mental illnesses in the DSM was a violation of the human right to be different, as upheld by the *Universal Declaration of Human Rights*, amongst others. But also demanding that treatment should be publicly funded is a violation of the human right to be different and to be treated equally regardless of one's arbitrary differences. In fact, offering special treatment to one category of potential applicants (transgenders) over other similar applicants, equally unhappy with the way they look, violates the human right of the latter category to be treated with equal concern and respect, and continues to condemn the group of transgenders to the stigma of being a category apart.

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notions
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benefits'

SCENARIO 1 (continued)

From all this, a number of consequences follows: society has a responsibility to reduce the stigma associated with one's arbitrary features (ethnic origins, age, sex, and gender). Nonetheless, the principle of autonomy over one's body cannot and should not be abridged: people should retain the freedom to modify their body, to the extent that this causes no direct harm to others or limits an equal freedom of others. Offering publicly funded treatment to the category of transgenders at the expense of other categories of people seeking body modifications limits the equal freedom of these others; it also continues to stigmatise the category of transgenders as 'special' and 'different' from all others. Therefore, treatment for gender issues should be a matter of private transaction. Within the limits imposed by the duty of care and professional obligations, doctors and patients should negotiate desired outcomes, and patients should pay for their own treatment.

should not be understood narrowly as risks/benefits of the treatment only, but should include an assessment of the overall consequences of treatment *versus* failure to administer treatment upon an applicant's welfare. For example, someone with

so
called
body
dysmorph
hic
disorder
could
receive
amputati
ons,
even if
this is
clinically
unnecess
ary, in
order to
prevent
greater
harm.²⁵

SCENARIO 2

S2.1 Felines, Star Treks, and Other Varieties: Should Doctors Do This?

A woman has undertaken several surgical interventions to look like a cat. Some people apparently ask for medical help to replicate the characters of *Star Trek*.²²

Some want to have their tongue split into two, like snakes. Should doctors do this?

In principle, in England at least, doctors have no (legal) duty to satisfy people's requests for medical treatment. They do not have a duty to file my nose or jaws, should I wish to look like Julia Roberts, and certainly they do not have an obligation to help me look more feline. At the most, within the limits imposed by their duty of care, doctors have a legal and moral *right* to provide these treatments, provided that the applicants are capable of giving valid consent and that the treatment is in their best interests.

Whereas what is in someone's best interests may be debatable, and whereas it may be asked what my best interests may ethically impose on others, certainly omissions are not morally neutral options." Doctors' right not to treat is not absolute: they generally must provide cogent moral or clinical reasons to withdraw their services.²⁴ As we saw in Chapter 7, in England there is no duty to rescue at law, but in other countries such a duty is recognised, and even where it is not, such absence can be contested.

Professionals, including doctors, have a *duty of care* towards their patients/clients, which imposes them not to harm those under their care, even if they are consenting adults, unless the harm is inflicted to prevent even greater harm or to produce a significant benefit. Surgery, for example, causes harm to the patient, but it is justified if it minimises greater harm or leads to the acquisition of significant benefits to the patient.

If the
patient,
for
instance,
will
commit
suicide
unless
s/he
receives
such an
intervent

Human Rights Complaint 034 to UN

ion, the amputation is no less of a life saving intervention than an amputation for gangrene. Arguably, in these cases it would be unethical to deny such treatment, as the likely foreseeable consequences of omission are pernicious or fatal. This obligation can in these cases be subsumed under the rule of rescue. Even in countries where such obligation is not foreseen by current laws, such a rule is one of the most important principles of ethics, and should not be abridged only because existing legislation fails to recognise it.

Let's see what this all has to do with transsexualism and access to medical treatment.

S2.2 The Case of Gender Identity

Gender dysphoria is characterised by severe and persistent discomfort with the assigned gender. Where the condition is persistent, the psychosocial adjustment of the sufferer is typically very difficult. There is high suicidal ideation amongst gender minorities (including youth), especially when timely medical treatment has not been provided. Whereas doctors have no legal obligation, at least in England, to intervene at request, it can be argued that they should provide treatment for gender dysphoria when three important conditions are met: first, the person must be in distress, and his or her suffering cannot be ameliorated with psychological/social intervention (for example, with psychotherapy or family or school involvement); second, the applicant has been assessed by specialists, and it must be sufficiently clear that the person's gender identification is atypical and that the person will benefit from medical care; finally, it should be expected that not providing treatment is the most risky option: for example, it should be probable that the overall psychosocial sequelae associated with not providing treatment is pernicious and worse for the applicant than that associated with treatment. When these conditions are met, medical intervention is ethical, and it would indeed be unethical to deny it. This should stand not only for transgenderism, but also for other types of body dissatisfaction, whether 'cosmetic', 'racial', or otherwise.

It should in fact be noted that the comparison between 'racial', 'cosmetic' surgery, and medical treatment for gender dysphoria is misleading. It suggests that, if treatment for gender dysphoria *is on a par with* 'racial' or 'cosmetic' surgery, then doctors have no moral obligation to provide it, and even a contentious moral right to satisfy the applicant's requests. Instead, here it is not a matter of *first* determining whether the intervention for gender dysphoria is (or is *on a par with*) 'cosmetic' or 'racial' interventions and *then* deciding *on that*

164 Children with Gender Identity Disorder

SCENARIO 2 (continued)

basis whether medical treatment is ethically justified or not. Doing so begs the question as to why some requests are regarded as 'clinical needs' and others are not. Also, this is not a matter of drawing lists of demands that should or should not be fulfilled, based on the way in which these demands are qualified (as 'cosmetic' or 'racial' as opposed to 'medical'). It is instead a matter of assessing, together with the applicant, the overall expected consequences of treatment *versus not providing treatment*. Where the risk—benefit ratio appears to be in favour of medical intervention, then, *prima facie*, intervention should be provided, and society and the state have a responsibility to provide public support for requested interventions. This obligation can also be subsumed under the rule of rescue.

S2.3 Gender as a Social Construct

The suffering associated with gender dysphoria is caused to a significant extent by a suspect bipolar model of gender (see Chapter 2). Gender dysphoria is somehow construed around norms of social acceptability: these are scientifically ungrounded and also unethical, to the extent that they promote the idea that gender difference is a *deviance*. It could thus be argued that treatment for gender dysphoria is *on a par with* 'cosmetic' or 'racial' surgery, and that we shouldn't change people's bodies, we should change the social norms.

This argument reminds us of the responsibility that society has to ensure equal dignity for all, regardless of gender orientation. However, this argument misses out on some important points: first, many transsexuals do not wish *to conform to social stereotypes of masculinity or femininity*: in fact, they often depart radically from those. Many explore different gender identities in different contexts (use their female identity in some settings and their male identity in others); many take hormones to become more masculine or feminine, but want to keep their genitals. Many embrace various elements of both genders, well beyond the classic gender divide. Thus there is a difference between those who seek medical intervention *to conform* to social norms of acceptability and those who seek medical intervention against social stereotypes in order to express more fully who they are. Second, society should ensure that everybody's dignity and rights are protected regardless of arbitrary features such as race, age, and gender. But

Human Rights Complaint 034 to UN

from this it does not follow that gender minorities should receive no medical care (or no funded medical care). Of course, if society is wrong we should change society. However, this does not imply that we should deny medical treatment that may also be necessary in order to ensure that everybody's differences are respected and protected. If it is possible to alleviate people's suffering, then there is a *prima facie* stringent moral reason to do so.

This has important ethical implications for medical practice.

S2.4 Ethical Implications for Medicine

Doctors perhaps have a responsibility not to reinforce mistaken norms of social acceptability (as the fashion industry and the media, for example, also have).

Should Gender Minorities Pay for Medical Treatment? 165

SCENARIO 2 (continued)

However, they have a responsibility to alleviate people's suffering and ameliorate their quality of life. A principle of minimisation of harm and a principle of beneficence are found in virtually all moral and professional codes. The fact that a condition is partly determined by social factors should not cloud our judgment in observing and assessing that condition. Infertility is in many cases socially induced. Many women, due to social variables, seek children later in life, when their fertility decreases. In those cases, infertility is clearly a function of social factors, but this does not imply that, *for that reason*, medical treatment should not be provided and funded publicly. The state also funds medical treatment for conditions on social and psychological grounds:" breast reconstruction after accidents or after breast cancer, surgery for bat ears, and hormonal treatment for excessive or retarded growth are all examples of interventions meant to align the person to social standards of normality.²⁷ These are typically funded publicly or reimbursed under many insurance schemes.

Even if suffering is to a significant extent socially determined, it does not follow that people should not receive treatment that is proven to alleviate their affliction. Only by tempering that distress and allowing people to flourish, will the medical profession promote acceptance for people's differences.

S2.5 A Matter of Private Transaction?

Even if gender dysphoria is not an illness, treatment should not be regarded as a matter of private transaction. First, not being an illness is normatively irrelevant in this sense: it is well known that some disability right activists contested that their conditions are not disabilities but different abilities." Some have tried to have deaf children, contending that deafness is indeed a privileged state.²⁹ This shows that the notions of disability/disorder are not just a matter of empirical or scientific observation, but a matter of value, and that their nature is elusive.

Therefore, these notions cannot be and should not be the standard test to decide whether people's claims should be satisfied and how. Moreover, the argument begs the question as to why some conditions (which appear deserving of treatment) are regarded as illnesses and others are not. Second, there are many conditions that are treated medically in spite of not being 'illnesses' (see previous section). If treatment for these conditions is offered, then *prima facie* treatment for gender dysphoria should also be offered on the same grounds: if it is likely to reduce suffering or prevent greater harm, is potentially life saving, and is likely to ameliorate the sufferer's quality of life.

S2.6 "All People Are Free in Dignity and Rights"...

... recites the *Universal Declaration of Human Rights*. Thus, people with similar problems should be treated similarly. To fund treatment for gender issues at the expense of equally valid claims is, it could be argued, an infringement of this important principle of ethics. However, gender dysphoria is not *on a par* with the wish to become feline or with the unease with some of our body

166 Children with Gender Identity Disorder

SCENARIO 2 (continued)

Human Rights Complaint 034 to UN

parts. First, for many of those affected, gender dysphoria is a terrible state to be in. If not treated, the psychological and social sequelae is for them grim and hideous (see Chapter 4). One may object that the psychosocial adjustment of the Cat Woman was very poor before becoming feline. However, there is much less evidence about the psychological dynamics and outcomes for those seeking 'racial' or 'cosmetic' (or feline) surgery. An empirical assessment of various applicants to treatment for gender dysphoria and other body modifications would be necessary before one can argue that these various conditions are on a par and should be treated in the same way. Second, receiving medical treatment is a life-or-death matter for many transgenders. In these cases, treatment should be regarded as life saving. Of course if rhinoplasty were to save someone's life, it should equally be regarded as life saving. Third, whereas the predilection for a smaller nose or a bigger breast can be a *preference*, it is not clear that gender dysphoria is a matter of preference in the same way. The onset of transgenderism is in many cases very early and is often persistent." It is thus likely that gender dysphoria has to do with early development of gender identity rather than with the susceptibility to and acquisition of social stereotypes.

Thus, gender variance is not comparable in all morally relevant senses to other types of body discomfort. The causes of this phenomenon are unknown and are probably multiple,³¹ but facts such as its severity and early onset may indicate that there is something not negotiable about atypical gender identification.

S2.7 Conclusions

Because atypical gender development is not to be regarded as an illness, therefore it should be considered on a par with other forms of body discomfort. This argument is incomplete. The fact that several types of body discomfort are not illnesses does not mean they are all *on a par*.

Because many types of body modifications are matters of private transaction, therefore medical treatment for gender dysphoria must also be. This argument is also flawed. It might well be that some other types of body modifications should also be funded publicly or reimbursed under insurance schemes.

From all this, a number of consequences follow: society has a responsibility to reduce the stigma associated with one's arbitrary features (ethnic origins, age, sex, and gender). This does not mean that all claims to body modifications deserve social support. It means that treatment (whether 'cosmetic' or otherwise) should be offered and publicly funded when the conditions discussed in the preceding are met. Whether or not medical treatment should be offered and paid for depends not on the type of condition one has, but on whether the condition (whether associated with gender, ethnic belonging, or others) is severe enough to impinge significantly upon the quality of life of the sufferer, to markedly jeopardise his or her psychosocial functioning, and whether available medical treatment is likely to ameliorate his or her condition.

Should Gender Minorities Pay for Medical Treatment? 167

5 CONCLUSIONS: WHAT WE HAVE REASON TO PREFER

The Polish film director and writer Krzysztof Kieslowsky produced a film in 1982, called *Blind Chance*, from which perhaps *Sliding Doors* took inspiration. The film splits in three, rather than two, stories. At the beginning of the film, Witek, the protagonist, runs to the station to get a train to Warsaw. He crashes into an old man who is drinking a beer. In one scenario, he ignores the fact and, in a moment, he is able to jump on the last carriage of the already moving train. In the second scenario, he just apologises quickly, but nonetheless misses the train. In the third, he stops to help the old man and misses the train. His life, from now onwards, depends on whether he apologises for spilling the beer of an old man. The paths his life takes, depending on these seemingly inconsequential facts and choices (an old man is in his way and how he decides to respond to his disappointment), are drastically different.

The moral of the film is as obvious as it is somehow disquieting: accidental facts beyond our control, combined with the moral choices we and others may make, can radically change our life. This incontrovertible truth goes often unnoticed, and the film brings it to light and compels us to think about the moral responsibility we bear when the actors are us.

In this chapter, I have wanted to highlight some of the complexities relating to the treatment of gender identity issues. Both scenarios offer seemingly plausible arguments for and against providing publicly funded treatment for gender dysphoria. But what is more important is what these parallel railways may tell us: the

Human Rights Complaint 034 to UN

moral choices that the actors may make over the random facts of our life (I happen to be born black or short, or I happen to develop my gender in an atypical way in Thailand, rather than Belgium rather than in Bristol, where both society and the medical profession may make a number of diverse moral choices relating to my condition) can have a number of consequences in our own lives. In this light, it becomes imperative that we, as actors, take the course of action that, with the insight of available evidence, is likely to promote the best outcome and to minimise the risk of highly negative consequences.

We have seen in detail in the course of this book the aftermath of untreated gender dysphoria. This includes psychological, physical, and social harm. For many transsexuals, receiving proper medical treatment as well as psychological support is a life-or-death matter. Whatever other considerations may need to be addressed, there is thus a *prima facie* moral reason to provide treatment. Whereas there may be a case for reconstructing healthcare funding perhaps according to personal finances (as is the case in some countries, where people may have to pay for a share of the healthcare costs according to income³²), and whereas certainly there is a case for improving social acceptance of

168 *Children with Gender Identity Disorder*

gender minorities, the compelling reason to offer medical intervention is that the condition, whatever its aetiology may be, is severe, and medical treatment can make the whole difference between one life that is acceptable and relatively flourishing and another life which is condemned to overarching grief.

B.4 The Lancet - Insight - News - Is change possible?

The social media response to the tragic death by suicide of 17-year-old transgender teenager Leelah Alcorn in Ohio, USA, has stirred up a storm of vitriolic blame and anger, beyond the confines of the lesbian, gay, bisexual, and transgender (LGBT) community. The outpouring of grief and rage is understandable, as is the resulting entrenchment of firmly held opinions.

But this risks clouding or overriding the complexities of transphobia—experienced at home, school, work, and in the community—which is so ingrained in society that it permeates every facet of life.

Calls for a ban on the controversial so-called conversion or reparative therapies that attempt to “cure” same-sex attraction or those who do not conform to gender-binary types have been re-awakened. In the USA, California and New Jersey are the only states that have enacted a bill banning the therapy. In the UK, major professional bodies are unified in discouraging this treatment as nonevidence-based and unethical. Even if prohibition was achieved, how might it prevent those exercising their rights under religious freedom not to practise it in less overt ways?

The American Psychiatric Association (APA) issued a position statement on August 16, 2012, that supports access to care and civil rights for transgender individuals. The statement refers to the insufficient access to health care and medical intervention, widespread discrimination, fear of hate-crime, and unique social challenges faced by transgender individuals, points out alarmingly high rates of death by suicide, and calls on more laws to protect their civil liberties. Unquestionably, all these inequalities and disadvantages qualify for immediate and effective redress, but one significant question remains, how does this really help adolescents who are supposedly led to believe that to live as a transgendered individual is unattainable?

Ohio rates poorly in LGBT equality, as presented in a state-by-state comparative analysis by the Transgender Law Centre. TransOhio, a support and advocacy group for transgender communities and individuals provides signposting for crisis intervention organisations, such as The Trevor Project and The Trans Lifeline. However, accessing such organisations might be a problem, especially for young people facing painful choices that risk alienating them from their communities and loved ones.

Family and society undoubtedly have a responsibility to promote a culture of acceptance, but pointing the finger at individuals is shortsighted. Strong opinions about the damage of fundamentalist religious morality need to be addressed, particularly for those who might experience opposition, intolerance, and denial of a personal identity that they themselves could be struggling to understand.

Is dialogue between the medical profession, transgender advocates, and the religious communities who advocate re-orientation possible? What role should the law have in protecting mental wellbeing, and how much does this collide with religious freedom? There are no easy answers, but the least health-care professionals and advocates can do is keep asking tough questions.

Jules Morgan

For more on the **petition from the Transgender Human Rights Institute to ban genderconversion therapy**

see <https://www.change.org/p/barackobama-enact-leelah-s-law-to-ban-transgender-conversiontherapy/u/9190451>

For **statements on conversion therapy from professional UK bodies**

see http://www.ukcp.org.uk/UKCP_Documents/policy/Conversion%20therapy.pdf

For the **American Psychiatric Association position statement**

see <http://www.psychiatry.org/advocacy--newsroom>

For the **Transgender Law Centre equality map**

see <http://transgenderlawcenter.org/equalitymap>

For **TransOhio** see <http://www.transohio.org/wordpress>

For more on **The Trevor Project**

see <http://www.thetrevorproject.org>

For more on **The Trans Lifeline**

see <http://www.translifeline.org>

MCB Note: Curiously this UK article addresses trans' problems in USA, without noting that the UK trans have very similar difficulties in UK society. It is quite common to find that it is easy to criticize another country, but much harder to sort out our own backyard?

B.5 The Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey (Youth'12)

The Health and Well-Being of Transgender High School Students: Results From the New Zealand Adolescent Health Survey (Youth'12)

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IMPLICATIONS AND CONTRIBUTION

This nationally representative survey is the first to report on the overall health and well-being of transgender young people. It is important that population based surveys recognize that not all people assume the gender of their natal sex. Schools, health services, and communities must consider that transgender youth represent an important population that has specific needs.

ABSTRACT

Purpose:

To report the prevalence of students according to four gender groups (i.e., those who reported being non-transgender, transgender, or not sure about their gender, and those who did not understand the transgender question), and to describe their health and well-being.

Methods:

Logistic regressions were used to examine the associations between gender groups and selected outcomes in a nationally representative high school health and well-being survey, undertaken in 2012.

Results:

Of the students ($n = 8,166$), 94.7% reported being non-transgender, 1.2% reported being transgender, 2.5% reported being not sure about their gender, and 1.7% did not understand the question. Students who reported being transgender or not sure about their gender or did not understand the question had compromised health and well-being relative to their nontransgender peers; in particular, for transgender students perceiving that a parent cared about them (odds ratio [OR], .3; 95% confidence interval [CI], .2e.4), depressive symptoms (OR, 5.7; 95% CI, 3.6e9.2), suicide attempts (OR, 5.0; 95% CI, 2.9e8.8), and school bullying (OR, 4.5; 95% CI, 2.4e8.2).

Conclusions:

This is the first nationally representative survey to report the health and well-being of students who report being transgender. We found that transgender students and those reporting not being sure are a numerically small but important group. Transgender students are diverse and are represented across demographic variables, including their sexual attractions. Transgender youth face considerable health and well-being disparities. It is important to address the challenging environments these students face and to increase access to responsive services for transgender youth.

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Summary of main findings

To the best of our knowledge, no nationally representative survey has published results pertaining to the overall health and well-being of transgender adolescents (or adults). We investigated gender groups and associations with protective factors, violence or personal safety variables, and health and well-being indicators in a large national survey of secondary school students in New Zealand. We concur with Goldblum and colleagues that transgender young people are "diverse in both identities and experiences" [9] (p. 474). Most of the transgender students surveyed reported that they had at least one parent who cared for them, that school was okay, that they felt safe in their neighborhood, and that they were not suicidal and did not have significant depressive symptoms. However, transgender students and those who were not sure or did not understand the question were at increased risk of being bullied, having physical fights, depressive symptoms, and suicide attempts, and being unable to access health care compared with their non-transgender peers.

This is in line with previous research showing that transgender young people are at greater risk of mistreatment [16], depression, self-harm, and suicide [14,15].

A small but important proportion of students reported being transgender (1.2%). This proportion is comparable to a study using a community sample of young people in North America [14], and it is similar to a recent estimate of the overall prevalence of transgender people [11]. By contrast, prior research has reported much lower rates than in our study [12], but those data were based on people accessing specialist clinics over a 40-year period [24].

With increasing age, the proportion of students who did not understand the question about whether they were transgender appeared to decrease, whereas the proportion that was not sure was similar by age group (compared with non-transgender students).

Furthermore, although more than a quarter of transgender students were aware of being transgender at a young age, just over half of transgender students in our study reported that they had first wondered about being transgender after the age of 12 years (which is similar to the proportion of same sex attracted students aware of their sexual attractions in New Zealand [25]).

Taken together, these factors indicate that adolescence is a time when a number of young people are making sense of their gender. Over 60% of transgender students had not disclosed being transgender, which is equivalent to the proportion of same/both sex attracted students who had not come out in relation to their sexual attractions in New Zealand [25,26].

B.6 Reported Emergency Department Avoidance, Use, and Experiences of Transgender Persons in Ontario, Canada:

Results From a Respondent-Driven Sampling Survey

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Study objective:

Transgender, transsexual, or transitioned (trans) people have reported avoiding medical care because of negative experiences or fear of such experiences. The extent of trans-specific negative emergency department (ED) experiences, and of ED avoidance, has not been documented.

Methods:

The Trans PULSE Project conducted a survey of trans people in Ontario, Canada (n¼433) in 2009 to 2010, using respondent-driven sampling, a tracked network-based method for studying hidden populations. Weighted frequencies and bootstrapped 95% confidence intervals (CIs) were estimated for the trans population in Ontario and for the subgroup (n¼167) reporting ED use in their felt gender.

Results:

Four hundred eight participants completed the ED experience items. Trans people were young (34% aged 16 to 24 years and only 10% >55 years); approximately half were female-to-male and half male-to-female. Medically supervised hormones were used by 37% (95% CI 30% to 46%), and 27% (95% CI 20% to 35%) had at least 1 transition related surgery. Past-year ED need was reported by 33% (95% CI 26% to 40%) of trans Ontarians, though only 71% (95% CI 40% to 91%) of those with self-reported need indicated that they were able to obtain care. An estimated 21% (95% CI 14% to 25%) reported ever avoiding ED care because of a perception that their trans status would negatively affect such an encounter. Trans-specific negative ED experiences were reported by 52% (95% CI 34% to 72%) of users presenting in their felt gender.

Conclusion:

This first exploratory analysis of ED avoidance, utilization, and experiences by trans persons documented ED avoidance and possible unmet need for emergency care among trans Ontarians. Additional research, including validation of measures, is needed. [Ann Emerg Med. 2014;63:713-720.]

INTRODUCTION

Background

Trans people may identify as transgender, transsexual, or as men or women with a history of transitioning sex ([Appendix 1](#)). Though historically assumed to be a minute minority, a recent household probability sample of Massachusetts residents found that 0.5% of adults identified as transgender, broadly defined to include all who “experience a different gender identity from their sex at birth.”¹ It is therefore likely that all emergency department (ED) providers have provided and will provide care for trans patients.

Trans people may be identified by ED providers because of incongruent sex markers on charts, visible gender variance, or anatomic differences from nontrans women and men. However, many others may not be readily recognized² either because they have not made changes to their appearance or because they have completed a social and medical gender transition and fully blend in their felt gender (also referred to as identified gender, core gender, chosen gender, or target gender). This lack of recognition is compounded by the limited visibility of trans health issues and trans patients in information (eg, medical education) and institutional (eg, medical record) systems.³ Recent non–peer reviewed literature reports from the United States suggest that trans people may avoid disclosure of gender identity or gender transition history because of fear of receiving poor care.^{4,5} These reports document a range of experiences, including postponement of care, care refusal, harassment, and even assault in ED settings.^{4,5}

Importance

Physicians have identified numerous barriers to competent care of trans patients, noting that because of limited clinical experience and a lack of trans-specific medical education,⁶ trans patients must often provide trans health care education to their physicians.⁷ In a survey of physicians about attitudes and practices with adolescent patients, emergency physicians were less likely than other physicians (family practice, pediatric, internal medicine, obstetrics/gynecology, and psychiatric) to discuss sexual orientation or gender identity with patients while taking a sexual history, most commonly because they believed it was not significant.⁸ Increased knowledge concerning the ED utilization patterns, experiences, and potential ED avoidance of trans persons could inform medical education curricula and affect physician attitudes and knowledge about the needs of trans patients.

B.7 Factors Impacting Transgender Patients' Discomfort with Their Family Physicians A Respondent-Driven Sampling Survey

Factors Impacting Transgender Patients' Discomfort with Their Family Physicians: A Respondent-Driven Sampling Survey

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Data Availability Statement: Because of a history of pathologizing research on transgender people in Ontario, wherein personal data had been used by a local institution in ways that the community considered highly problematic, this project required a long trust-building phase in order to make data collection possible. As part of that, we have promised that data will only be seen by members of our research team. This was in our letter of consent and is part of the Research Ethics Board requirements for this project. Therefore, we cannot place data in a data repository or make them freely available to others on request.

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Abstract

Background

Representing approximately 0.5% of the population, transgender (trans) persons in Canada depend on family physicians for both general and transition-related care. However, physicians receive little to no training on this patient population, and trans patients are often profoundly uncomfortable and may avoid health care. This study examined factors associated with patient discomfort discussing trans health issues with a family physician in Ontario, Canada.

Methods

Human Rights Complaint 034 to UN

433 trans people age 16 and over were surveyed using respondent-driven sampling for the Trans PULSE Project; 356 had a family physician. Weighted logistic regression models were fit to produce prevalence risk ratios (PRRs) via average marginal predictions, for transmasculine (n = 184) and transfeminine (n = 172) trans persons.

Results

Among the 83.1%(95% CI = 77.4, 88.9) of trans Ontarians who had a family physician, approximately half reported discomfort discussing trans health issues. 37.2% of transmasculine and 38.1% of transfeminine persons reported at least one trans-specific negative experience. In unadjusted analysis, sociodemographics did not predict discomfort, but those who planned to medically transition sex, but had not begun, were more likely to report discomfort (transmasculine: PRR = 2.62 (95% CI = 1.44, 4.77); transfeminine: PRR = 1.85 (95% CI = 1.08, 3.15)). Adjusted for other factors, greater perceived physician knowledge about trans issues was associated with reduced likelihood of discomfort, and previous trans-specific negative experiences with a family physician with increased discomfort. Transfeminine persons who reported three or more types of negative experiences were 2.26 times as likely, and transmasculine persons 1.61 times as likely, to report discomfort. In adjusted analyses, sociodemographic associations differed by gender, with being previously married or having higher education associated with increased risk of discomfort among transfeminine persons, but decreased risk among transmasculine persons.

Conclusions

Within this transgender population, discomfort in discussing trans health issues with a family physician was common, presenting a barrier to accessing primary care despite having a regular family physician and “universal” health insurance.

Introduction

Trans (transgender, transsexual or transitioned) persons are those whose gender identity or lived gender varies from their sex assigned at birth [1]. A population-based study from Massachusetts, USA, suggests trans people represent approximately 0.5% of the adult population [2].

Extrapolated to the 2008 population of residents of Ontario, Canada aged 15+, this would represent an estimated 53,500 trans Ontarians.[3] In Canada, management of hormone therapy, and referrals to and coordination with specialists and surgeons, falls within the scope of services provided by family physicians. In Ontario, 67.3% of trans people using hormones accessed them through a family doctor, and only 30.9% through a specialist [4]. Moreover, family physicians play a vital role in prevention and treatment of both general medical conditions and those related specifically to being trans [5]. However, both trans patients and their physicians have identified a lack of trans-relevant clinical training among primary care providers as a barrier to care [1,6,7], given limited coverage within medical education [8].

Under Canada’s provincial public health insurance systems, access to primary care is available free of charge to nearly all residents. The system does not have universal coverage; shortages of family physicians (particularly in rural areas) [9], and socio-cultural access barriers remain [10]. As a result, finding a new family physician can be difficult if one is not satisfied with care. Having a regular family physician and insurance coverage represents potential access to health care, the first step in access. Access must then be realizable (free from further barriers) before it can be realized (actually accessed). Patient-physician communication is considered to be crucial in the process of care, as it impacts both patient satisfaction and outcomes [11]. For trans patients, who may not be identifiable to physicians, communication regarding trans issues is also crucial to realizable access to both transition-related care and trans-competent primary care (the latter also for the 25% of trans people who do not intend to medically transition or are unsure [3]). However, factors that affect patient-physician communication regarding trans-specific health issues have been studied only in very limited ways. Qualitative studies suggest patient comfort discussing trans issues may be impacted by perceived physician knowledge, in the context of limited training [1,6,7].

Trans people have been identified as a medically underserved population that faces stigma within and outside of health care settings [12]. Difficulties in accessing healthcare have been reported in both primary and specialist care settings, including emergency medicine, with some trans persons reporting avoidance of health care due to fears of discrimination [1,13–15]. Frequencies of health care discrimination or avoidance have been shown to vary by age, race, socioeconomic status, gender, and medical transition status.[14–17], with stigma or discrimination contributing to health care avoidance or postponement [14,15] The impacts of this may be compounded by potentially higher need for some health care services; existing research suggests that trans people are at elevated risk for stress related to minority status [18], depression [19,20], suicidality [21], and HIV and other sexually transmitted infections [3,22,23]. Those

Human Rights Complaint 034 to UN

trans people who need to medically transition require medical care related to hormonal and/or surgical treatments [24]. Thus, facilitating access to trans-competent primary care is critical for the health of this underserved population. For trans people in Ontario, Canada's most populous province, the current analysis sought to estimate prevalence of, and identify factors associated with, discomfort discussing trans issues with one's family physician. We hypothesized that the likelihood of discomfort with trans-related physician-patient discussion is shaped by sociodemographic factors, including age, race, marital status and education, as well as trans-specific factors, including prior negative experiences with physicians, history of transphobic experiences generally, perceptions of physician knowledge, and medical transition status.

As research on factors associated with experiences of discrimination and health care avoidance has often been conducted using only transfeminine or only transmasculine participants [15,16], it is unclear to what extent these predictors may vary by gender spectrum. Given prior findings that predictors of other health-related outcomes may vary by gender spectrum [19,20], we hypothesized that predictive factors for discomfort discussing trans issues with a family physician may differ for those on the transfeminine and transmasculine gender spectra.

Methods

Survey Methods and Study Sample

As part of the Trans PULSE Project, a cross-sectional survey was conducted in 2009–2010, with data collected from 433 trans participants age 16 or older in Ontario. This remains the only large probability-based data set on trans health and health care in Canada. The survey was multi-mode, completed online or on paper. Participants (including minors age 16 and 17) were asked to indicate informed consent by clicking to begin the survey or by mailing in a completed copy; written signatures were not obtained in order to allow for participant anonymity, if desired. Consent procedures, along with other aspects of the study, were approved by Research Ethics Boards at The University of Western Ontario and Wilfrid Laurier University. Respondent-driven sampling (RDS), a method of tracked chain-referral sampling, was used for recruitment and analysis. RDS is designed to recruit and estimate the characteristics of hard-to-reach or "hidden" populations, those from which a random sample cannot be drawn [25,26]. Recruitment began with 16 seeds, representing a diverse group of original participants, with 22 seeds later added. Each participant was able to recruit up to three eligible peers, who could then each recruit up to three new participants. Recruitment continued until the tenth wave to ensure the attainment of equilibrium (i.e., sample composition stable and independent of the characteristics of seeds). Recruitment patterns were tracked using coupons, and individual network sizes were obtained for use in data analysis. Network characteristics and structure are displayed in Fig 1.

Because some trans people were only connected to trans communities electronically, while others did not have internet connections (or did not have high-speed internet, as was common in Ontario's rural northern communities), the survey was completed either online (392 participants) or on paper (41 participants), using visually identical survey versions. Online participants received their recruitment coupons online (which could then be printed if needed); paper participants received theirs via paper or e-mail as per their request. Coupons were identically worded and allowed new recruits to either login directly to the online survey or call our toll-free number to request a paper survey. Thus, recruitment chains rarely proceeded through only online or paper chains.

Results

Based on our weighted estimate, 83.1% (95% CI = 77.4, 88.9) of trans Ontarians had a family physician. Among those with a family physician, about half of transmasculine (47.7%, 95% CI = 36.6, 58.8) and transfeminine (54.5%, 95% CI = 42.9, 66.1) persons were not comfortable discussing trans issues with their doctor. Frequencies for sociodemographic and trans-specific factors potentially predictive of discomfort are presented in Table 1, for transmasculine and transfeminine Ontarians who reported having a family physician.

Unadjusted PRRs are presented in the first column in Table 2 for transmasculine persons and Table 3 for transfeminine persons, estimating actual observed differences in prevalence of discomfort between groups. Here, sociodemographic variables were not associated with discomfort discussing trans issues, but some trans-specific variables were. Level of prior transphobia experienced was significantly associated with increased risk of discomfort for transmasculine persons, and decreased risk for transfeminine persons. Medical transition status was significantly associated with discomfort for both gender spectra. Transmasculine persons who were in process of transition, and both transmasculine and transfeminine persons who were

Human Rights Complaint 034 to UN

planning but had not begun to medically transition, were more likely to report discomfort than those who described themselves as having completed a medical transition. For the transmasculine group only, having had three or more negative trans-specific experiences with a family physician was associated with increased risk of discomfort, and greater perceived physician knowledge about trans issues with decreased risk.

In multivariable analyses for transmasculine (Table 2) and transfeminine (Table 3) persons, in the models including only sociodemographics (Model 1), being previously married was associated with discomfort discussing trans issues among transfeminine persons, and no other variables were significantly associated. In the models controlling for both sociodemographic and trans-specific factors (Model 2), marital status and education became significantly associated with discomfort for both gender spectra, but in opposite directions. For transmasculine persons, being previously married (versus single and never-married) was associated with a 52% reduction in likelihood of discomfort (RR = 0.48; 95% CI = 0.23, 0.97), whereas for transfeminine persons it was associated with a 49% increase (RR = 1.49; 95% CI = 1.03, 2.14). As compared to postsecondary graduates, transmasculine individuals who had a high school diploma were twice as likely to report discomfort (RR = 2.01, 95% CI = 1.25, 3.22), whereas transfeminine persons were 63% less likely (RR = 0.37, 95% CI = 0.14, 0.96). Being a youth aged 16–24 was also independently associated with greater discomfort among transfeminine persons only. Trans-specific factors were associated with discomfort discussing trans issues for both gender spectra, independent of other sociodemographic and trans-specific factors controlled for in Model 2. Greater perceived physician knowledge about trans health issues was a strong predictor; having a somewhat to very knowledgeable physician was associated with a relative risk reductions ranging from 38% to 63%, depending on gender spectrum and level of perceived physician knowledge. Within the transmasculine group, those who had not medically transitioned (and had no plans to) were 56% more likely to report discomfort than those who had completed transition (RR = 1.56, 95% CI = 1.02, 2.38). Within the transfeminine group, exposure to higher lifetime levels of transphobia remained strongly associated with reduced discomfort. Previous trans-specific negative experiences with a family physician were strongly associated with discomfort, particularly among those on the transfeminine spectrum; those in this group who had experienced three or more of the specified negative experiences (see Table 4 for specific experiences and their frequencies) were 2.26 times (95% CI = 1.60, 3.20) as likely to report discomfort discussing trans issues with their family physician.

Discussion

To our knowledge, this is the first analysis examining factors associated with trans patients' access to family medicine specifically. In Ontario, a family medicine-based health system and

“universal” public health insurance without co-payments reduce barriers to physician care. In 2011, an estimated 90.9% of Ontarians had a regular family doctor [34], compared to 83.1% for Ontario's trans population in our results. Thus, trans people may be somewhat less likely to have a regular doctor, making them more dependent on walk-in clinics.

Having a physician represents potential for health care access, which may or may not be realized depending upon a patient's willingness and ability to access care, and the quality of that care relative to the patient's needs. The present study provides a first analysis of factors impacting realizable access to family physicians for trans people. Our estimate that half of trans patients report being uncomfortable discussing their trans status or trans health issues with their regular family physician indicates cause for concern. There is little available empirical evidence with which to compare our results. In a needs assessment of trans people in Virginia (n = 350), conducted using a convenience sample [35], 26% of those with a primary care provider reported being uncomfortable discussing trans-specific health care needs with their provider. Our higher proportion may reflect the broad nature of our RDS sample, in contrast to convenience samples which likely over-represent well-connected trans people who may have better access to trans-friendly health care.

Sociodemographic associations differed markedly across gender spectra, highlighting the importance of conducting analyses either stratified by gender spectrum or tested for interactions. In particular, after controlling for all other sociodemographic and trans-specific characteristics, higher educational attainment and being previously married were associated with increased likelihood of discomfort discussing trans status with physicians among transfeminine persons, but reduced likelihood among transmasculine persons, indicating qualitative effect measure modification. It is possible that these interesting findings are the result of chance and a peculiarity of our data set, and we would recommend further study of such effect modification. We do not know much regarding how relationship status or dissolution may differentially impact transmasculine versus transfeminine persons or the social support they receive. While

Human Rights Complaint 034 to UN

it has been shown that transfeminine persons are more likely than transmasculine persons to experience loss of employment and violence [14], which may impact expectations of poor treatment in other settings, job loss and violence were included within our transphobia scale, which was controlled for in this analysis. It would be of interest to explore whether those who experienced positions of greater social privilege prior to transition (e.g. trans women who previously lived as married men and/or well-educated men), and then experienced loss of status, may have less experience and comfort with navigating patient-physician interactions from a socially disadvantaged position.

Of those who reported having a family physician, we estimated that 37.2% of transmasculine and 38.1% of transfeminine persons had prior trans-specific negative experiences with family physicians. While this represents a sizeable proportion of trans patients, frequencies for individual negative experiences were generally lower than those reported within the same data

set for comparable experiences in emergency department setting [13]. A total of 31.2% of transmasculine and 40.6% of transfeminine persons perceived their physician to be not at all knowledgeable about trans health issues. Adjusting for all other sociodemographic and trans-specific factors, both prior trans-specific negative experiences and the perception of limited provider knowledge were predictive of discomfort discussing trans issues within both gender spectra. This is consistent with qualitative research in which trans participants link provider education/knowledge with comfort or access [1,6], as well as with quantitative findings that transfeminine persons with experiences of perceived discrimination in healthcare settings were twice as likely to avoid healthcare as those without such experiences [15].

More surprising was the finding that higher levels of transphobia were independently and negatively associated with discomfort among transfeminine persons, controlling for all other factors in the analysis; this may indicate the development of resilience and confidence in response to social stigma, particularly where the experiences were not directly related to prior experience in medical settings (which was controlled). Confounding by social transition status could be a plausible alternative interpretation (those who were “out” as trans may have been more likely to both be comfortable discussing trans issues with others, and to experience transphobia). However, inclusion of a social transition status variable in Model 2 had no substantial impact on results (not shown), demonstrating no support for this possible explanation.

In adjusted analysis, medical transition status was only associated with discomfort for transmasculine persons, among whom discomfort was more likely for those who had not medically transitioned (and had no plans to), as compared to those who had completed medical transition. This may be related to reduced gender identity affirmation experienced by trans people who do not wish to medically transition. We note that in unadjusted analysis, discomfort was more likely among those who were planning to medically transition (for both gender spectrum groups), but had not begun, representing an actual higher prevalence of discomfort in this group. Among this group, discomfort discussing trans issues with one’s physician could reflect anxiety about the potential for the physician to restrict or deny access to transition-related care, and could present an obstacle to beginning a planned medical transition.

Limitations

Our findings need to be interpreted in the context of the limitations of this study. Since our study included questions regarding experiences with a “regular family physician”, it is unclear to what extent our results would apply to other primary care providers, such as physicians at walk-in clinics or nurse practitioners. As with all studies, it is possible that some findings are chance results, and are due to peculiarities in this particular data set. Our measures also had limitations. We note that our measure of previous negative experiences with a family physician did not distinguish between experiences with past or current physicians, which would have aided in interpretations of our findings. Given the lack of validated measures for transspecific constructs, many of the measures used in our study were derived by our research team. The list of trans-specific negative experiences did not encompass many experiences that may be common; for example, we asked if a provider had refused to examine parts of a participant’s body because they’re trans, but not whether they had asked to examine body parts not relevant to the issue for which one was seeking care. Also, all items are self-report. We note that patient perceptions of physician knowledge do not necessarily reflect actual physician education. Nevertheless, patient perceptions are relevant even if physicians were indeed well informed, given their demonstrated association with patient discomfort and its potential impact on quality of care.

Implications

The high proportion of trans patients who reported discomfort discussing trans issues highlights the need to support health care policy-makers and providers in creating trans-inclusive

Human Rights Complaint 034 to UN

environments and providing integrated and comprehensive services that actively address trans health needs in primary care settings.

The trans-specific negative experiences we have documented may provide some guidance as to areas for action. Trans-specific negative experiences that are hurtful or awkward, such as having a physician think a sex designation on an identity document or record is a mistake, or use insulting language, may impact a patient's future comfort and likelihood to access care. Physician resources for cultural humility in the care of trans patients are available [36], and recently published practical recommendations for electronic medical records may also help alleviate some of these issues [37–39]. Other negative experiences go well beyond awkwardness and may directly compromise quality of care. That trans patients reported having family physicians refuse to discuss trans issues, refuse to examine parts of their bodies, or end care because they were trans suggest violations of physicians' duty to care.

The most common negative experience with a family physician reported by trans patients was being told the provider did not know enough about trans-related care to provide it for them. It was not clear to what extent this was an accurate assessment of lack of training in transition-related care, versus a reflection of situations where a physician assumed that trans-specific knowledge was necessary for general care. A tendency for providers to attribute potentially unrelated health conditions to gender or to hormone treatment was documented in this study's initial qualitative phase [1]. This points to the importance of incorporating trans cultural humility and clinical care needs into existing medical education for family physicians. For example, trans sensitivity education could be incorporated into existing cultural competency/humility modules, while basic hormone treatment information, as well as guidance on when specialist consultation is indicated, could be included in endocrinology-related curricula. Such education is recommended by existing trans care guidelines [36], and supported by the Canadian [40] and American Medical Associations [41].

Overall, our findings show that even in a context of universal basic health insurance, barriers to trans-specific primary care remain. That trans persons were somewhat less likely to have a regular family physician and that half of these reported discomfort discussing trans-specific issues with their physician highlights the distinction between potential access and realizable access within a system where basic transition-related care (i.e. hormone therapy, as well as referrals for any surgical needs) is generally provided in the context of family medicine.

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Author Contributions

Conceived and designed the experiments: GRB XZ AIS RH AT. Analyzed the data: GRB AIS. Wrote the paper: GRB XZ AIS RH AT. Collected the survey data: GRB RH.

Human Rights Complaint 034 to UN
Appendix C. Cost Per QALY calculations for Trans Healthcare

These estimates are based on WHO Common values in assessing health outcomes from disease and injury: disability weights measurement study for the Global Burden of Disease Study 2010 and Appendix 2013.

This procedure provides a formal analysis method, which reduces the effect of prejudices on intuitive methods of decision making. This then provides much greater protection for unpopular or marginalized groups of patients.

The Disability weights used, were interpolated from the reference, intuitively.

	Disability weight		one off cost		Benefit duration	ongoing cost/year
	MtF	FtM	MtF	FtM	years	
No treatment	0.4	0.27	na	na	na	-
GNrH prior to						
puberty	0.10	0.07	\$10,000	\$10,000	45 years to age 60 max	-
Hormones &						
psychotherapy	0.15	0.12	\$17,500	\$15,000	45 years to age 60 max	\$ 1,000
Social Worker						
support	0.05	0.03	\$12,500	\$10,000	50 years to age 60 max	\$1,000
MtF Other treatments and welfare issues not included in this analysis (for simplicity or treatment for the issue is						
not feasible)	0.05	na	na	na	na	na
FtM Breast removal						
(if no GNRH)	na	0.03	na	\$7,000	55 years to age 70 max	
GRS	0.05	0.02	\$25,000	\$50,000	50 years to age 60 max	

Human Rights Complaint 034 to UN Comments

FtM experience less social stigma, with treatment and without treatment. This results in slightly better QoL without treatment and with treatment, than MtF.

This also results in less requirement for psychotherapy and social worker support.

By giving GnRH prior to puberty, adults pass much better in their assigned sex. This results in much reduced social stigma, better social and intimate relationships and better opportunities to form successful sexual relationships.

For FtM, GnRH treatment prior to puberty removes the need for breast removal, which alone fully covers the cost of GnRH treatment. For no additional cost a whole of adult life improvement of 0.05 Disability factor is obtained. (For an assumed life value of \$4 million eg taken from road safety economic studies, this disability is valued at \$200,000.) The \$/QALY for the GnRH treatment is $\$0/0.05/40 \text{ years} = \free/QALY . It should be impossible to deny access to such a treatment.

For MtF, GnRH treatment prior to puberty, for the additional cost of only \$11,000 a whole of adult life improvement of 0.05 Disability factor is obtained. (For an assumed life value of \$4 million eg taken from road safety economic studies, this disability is valued at \$200,000. The \$/QALY for the GnRH treatment is $\$5,000/0.05/40 \text{ years} = \$2,500/\text{QALY}$).

It would appear heartless and cruel to deny patients a treatment as cheap as \$2,500/QALY, yet in NZ many potential patients are denied this treatment by the denial of public information about this treatment. This particularly affects trans children who are trying to live in denial.

By comparison, the USA Veterans Administration pays up to \$400,000 for genital repair surgery for US soldiers injured in Afghanistan and Iraq. As these surgeries are often severely limited in the degree of disability reduction that can be obtained, this shows how highly functional sexuality is valued for young heterosexual men, who have already had the luxury of having had a healthy functional sexual life.

(It also shows how lowly transsexuals' access to a satisfying social and sexual life is valued by ADHB. It appears to be very easy for ADHB planners and doctors (who have had the luxury of having a healthy and functional sexual life) to see very little value in trans' quality of life and relationships?)

Hormones provided over up to 50 years & psychotherapy provided over 5 year period.

Social Worker support provided over 5 year period.

MtF other treatments and welfare issues – this line is included to make the shown Disability weights sum to the untreated value. Some of such treatments are: (not required if GnRH treatment was provided)

voice training

voice pitch raising operation on larynx

facial feminisation surgery

Adam's Apple shave

Loss of life to suicide should be included, but time ran out while this was being prepared. This would reduce the cost/QALY in all cases, further increasing the justification for these treatments.

Maybe my calculations have errors in them. Even so, I don't believe that these could be large enough to alter the conclusions. That is what really matters.

Health Economics Analysis of Trans Treatment Options

Where treatments are below the nominal benchmark for approval of \$20,000 to \$30,000 per QALY, then the patient should be offered the choice of which treatment option to proceed with.

These analyses have not adjusted for the time value of money. This reduces the effective cost of future expenditures, thus improving the justification for all options from the results shown here.

MtF cases \$/QALY

MtF entry prior to puberty, no GRS
GNrH, H&P, SW 5667 $= (10000 + 17500 + 12500 + 45 \times 1000) / (0.1 + 0.15 + 0.05) / 50$

MtF entry prior to puberty, with GRS
GNrH, H&P, SW, GRS 6286 $= (10000 + 17500 + 12500 + 25000 + 45 \times 1000) / (0.1 + 0.15 + 0.05 + 0.05) / 50$

MtF entry aged 20, no GRS
H&P, SW 7500 $= (17500 + 12500 + 45 \times 1000) / (0.15 + 0.05) / 50$

MtF entry aged 20, with GRS
H&P, SW, GRS 8000 $= (17500 + 12500 + 25000 + 45 \times 1000) / (0.15 + 0.05 + 0.05) / 50$

MtF entry aged 50, no GRS
GNrH, H&P, SW 10000 $= (17500 + 12500 + 10 \times 1000) / (0.15 + 0.05) / 20$

MtF entry aged 50, with GRS
H&P, SW, GRS 16250 $= (17500 + 12500 + 25000 + 10 \times 1000) / (0.15 + 0.05) / 20$

FtM cases As GRS is expensive and outcomes are not so good, GRS cases will not be presented here.

FtM entry prior to puberty, no GRS
GNrH, H&P, SW 7273 $= (10000 + 15000 + 10000 + 45 \times 1000) / (0.07 + 0.12 + 0.03) / 50$

FtM entry aged 20, no GRS
H&P, SW, BR 10267 $= (15000 + 10000 + 7000 + 45 \times 1000) / (0.12 + 0.03) / 50$

FtM entry aged 50, no GRS
H&P, SW, BR 14000 $= (15000 + 10000 + 7000 + 10 \times 1000) / (0.12 + 0.03) / 20$

Conclusions:

All of the treatment options easily meet the funding threshold.

Therefore, the patient should be offered all of these treatment options.

The calculations above should be adjusted for equity. This would further improve the justification for approving all of the trans treatments shown above.

The fact that trans' healthcare is provided on such a prejudicial and iniquitous basis, must be seen as a serious breach of Human Rights by ADHB.

Appendix D. Health Minister Dr. Jonathon Coleman's Nutty Comments About Funding For GRS

Free surgery bid "nutty" Health Minister Jonathan Coleman

The following article shows that Dr. Jonathon Coleman's decision about the adequacy of trans healthcare in NZ was intuitive and emotional, not based on cost per health improvement in Quality Adjusted Life Years (QALY).

The QALY (Quality or Disability Adjusted Life Year) approach was developed by Harvard University public health specialists, for prioritising healthcare decisions, to ensure fairness of access to medical treatments, even for marginalized groups within society disadvantaged by social and medial prejudices.

It would appear that Dr. Jonathon Coleman, Minister of Health, hasn't even heard about QALY and equity of access to medical treatments. This should bring into question his fitness for his job as Minister, as one of the main functions is ensuring equitable access to healthcare for all NZers.

Similarly, there has been no comment by medical practitioners about Dr. Jonathon Coleman's competence either as a doctor or as Minister of Health. Should that call into question NZ doctors commitment to equitable access to healthcare?

Free surgery bid "nutty" - Health Minister

Posted in: [New Zealand Daily News](#)

By GayNZ.com Daily News staff - 19th May 2015

http://www.gaynz.com/articles/publish/2/article_16854.php

UPDATED: A move within the Labour Party to push for free gender-reassignment surgery is being slammed before it's even gained significant traction.

ONE News reports at least one regional party conference has voted for a remit to make the expensive surgery free.

It's already a Rainbow Labour policy to "review funding and access to gender transition procedures".

After hearing about the plan for free surgery, which has come from the party's youth wing, *Stuff* asked a number of MPs for their thoughts at Parliament today.

It says Health Minister Jonathan Coleman described the proposal as a "nutty idea" which was not high on his list of priorities, and reflected the focus of the Labour Party.

"I think they're totally out to lunch and it shows you why these people will be unelectable for a very long time."

Labour leader Andrew Little didn't know much about it and said he hadn't given the policy much thought, stating "I'm quite happy with my gender." He added it was complex and "and not an issue I'd make a policy up on the hoof."

Labour's Napier MP Stuart Nash said he didn't think it was an important issue for New Zealanders.

"To be honest, never once in Napier has anyone ever said they're not going to vote for Labour because we're not funding gender reassignment surgery."

According to the report, Rainbow Labour MP Grant Robertson said he didn't feel strongly either way, but acknowledged it was a "complex issue" that would be an "expensive undertaking".

However Robertson, who has been a solid lgbti advocate in Parliament, says he was not actually asked a question about trans health care, but about open ended funding of surgery.

[Read what other MPs had to say here](#)

At the moment, four gender reassignment surgeries are supposed to happen every two years under the Ministry of Health's high cost treatment pool.

However surgeries have been on hold since the only surgeon who carried them out in New Zealand retired.



Jonathan Coleman says it's a "nutty idea"

Human Rights Complaint 034 to UN

There have been 68 applications for funded gender reassignment surgery over the past seven years, and just nine surgeries have been carried out.

Those who can afford to, have the surgeries overseas. Others are beginning to turn to crowdfunding to raise the cash.

Among the crowdfunders is [Jennifer Shields](#), who has previously blogged she needs surgery. "I need it to be able to continue living my life – the longer I go without it the harder things get and the closer I am to dying."

Today, Shields tells *GayNZ.com Daily News* the waitlist is 40 years long, "and that's longer than our life expectancies".

She continues: "That's not good enough, and Labour's attitude towards the surgery is incredibly disappointing. I'm glad that Little is 'happy with [his] gender' but that doesn't mean that trans people should go without surgery that will save lives and significantly improve mental health.

"Stuart Nash seems to think there are no trans people in his electorate, which is an old excuse we've heard time and time again: 'oh, there's no one like that here, so it doesn't matter'.

"The MPs interviewed by Stuff all seem to be valuing what's popular amongst their voters instead of what a significant part of our population needs to live beyond 40."

[Jennifer Shields has blogged more about the issue here](#)

Lynda Whitehead from trans rights and support group Agender is incensed.

"It's absolutely appalling what has been done, or more correctly not done," she says.

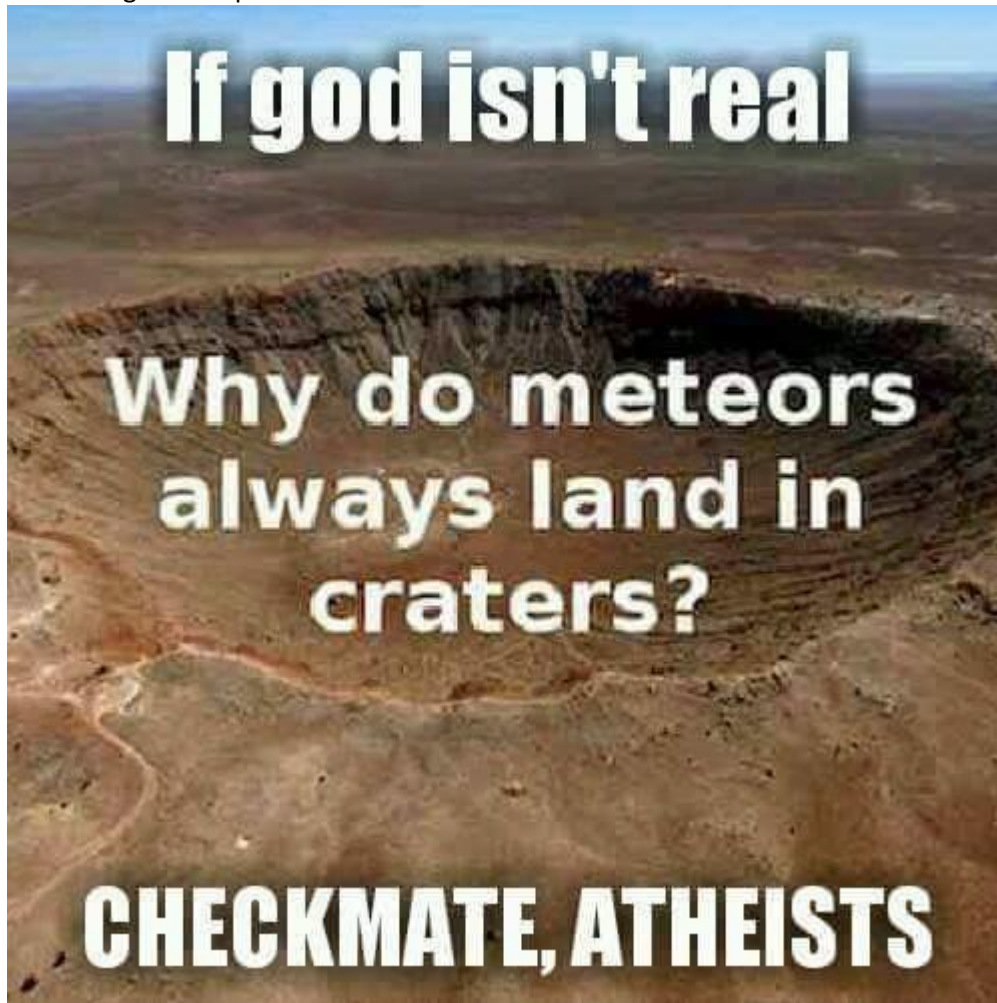
"And to label this as 'nutty' is ignorance and arrogance at its worst."

Kelly Ellis from TransAdvocates, who was a Labour candidate at the last election, says if the Minister of Health "is calling mainstream medical treatment nutty, then we've got a quack in charge of this important portfolio".

She adds: "These views, disproven by science, are Flat Earth country. I'd hope the Minister is better briefed before he embarrasses himself further."



[Jennifer Shields is crowdfunding for surgery](#)



Appendix E. The waiting game waiting for GRS in NZ By Jacqui Stanford 2012

Posted in: [People](#)

By Jacqui Stanford - 1st June 2012

http://www.gaynz.com/articles/publish/33/article_11825.php

It's no secret that the people who reside under the so-called 'transgender umbrella' are as varied as Auckland's weather patterns. One group of pre- and post-op transsexual women is stepping out from under the brolly, and they aren't fazed by being seen as separatists, saying they just want movement on the issue that most impacts them: the longer than long waiting list for gender reassignment surgery in this country.

I met with two pre-op transsexual women and some of their post-op supporters at a downtown Auckland café. The meeting came about due to the frustration they are feeling at the years of waiting they are facing for surgery. They tell me those who can afford it go to Thailand. Those who can't are left scrounging every penny, feeling like their lives are on hold and they are incomplete, at the mercy of a Government that doesn't seem interested.

The Ministry of Health funds gender reassignment surgery under its High Cost Treatment Pool, however there are 53 people on the waiting list and, according to the Ministry, an average waiting time of seven years.

Simone Whitlow, 36, works for an Auckland finance company and began transitioning while working for her company five years ago. She has been on hormones for a little over two years. Yet to have surgery, she feels deformed.

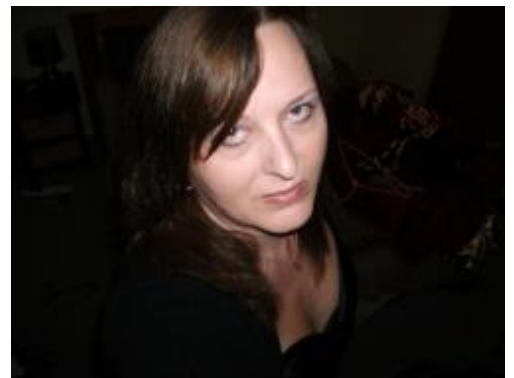
"For me personally it's that I have a hard time trying to have a relationship with someone while the plumbing's all messed up," she explains.

"I do tend to think of that way; you wouldn't leave somebody with a cleft palate forever and a day, 26 years on a waiting list. Or with horrible burns maybe. And to me I guess that's the thing: it's not an elective surgery we're asking for. It's to fix what's horribly wrong and allow us to have normal lives, normal being the key thing I think."

Whitlow says while transitioning and beginning hormones makes you feel better and improves your life a thousand per cent, there is still an overriding feeling of incompleteness. "It's definitely something that completes your life and allows you to move on, in terms of all the paperwork and everything, and emotionally," she says of surgery.

She has been on the waiting list since late last year and was recently informed of the seven year backlog. "But the more I hear from them, it's not so much a seven year backlog, as much as these are the next seven years' worth of people. But they say it will be a very long time, no specified amount, and there are 40-odd people ahead of me on the waiting list. So for every two years, it's a long, long waiting list. It could be 25 years if every single person is truly in need of the operation and meets the guidelines. So it's anyone's guess: at least seven years, it could be 26," Whitlow says.

"I guess for me that's the main issue really: the issue that it's a long, long waiting list. And that actually when you've got a doctor that by all accounts is due to retire, and you've got the money there to actually get things moving along, you'd get three times as many through if you actually send us to Thailand. I think a lot of us on the list wouldn't have any issue, we'd come up with the money come hell or high water, to fly ourselves there and back. "The surgery costs about \$45,000 in New Zealand, but is about a third of that in Thailand."



[Simone Whitlow](#)

Human Rights Complaint 034 to UN

"To me that's the issue in a nutshell," Whitlow says. "The Government can get three times the productivity for the same money, and we are suffering. I'd like to see it 'man up' and look at that properly."

Whitlow thinks there is a lot of public confusion about what having surgery actually means to pre-op transsexuals, even within our own community. "The transgender groups, the wider umbrella, actually encompass a lot of cross-dressers, gender variant people and people who believes there are third gender, and all the rest that goes with that. It muddies the issue. To us it's a very simple thing: we get operated on, we are then 100 per cent woman. We move on with life. So I think in the din of all that's come from them and various other groups, glitter-bombing feminist icons and all the rest, we've been lost in there, is the key thing."

She says there are of course other transgender issues out there, but for her and others waiting for surgery, it is the biggest one.

Rachael McGonigal, who is post-op and had her surgery overseas, chips in with her recent realisation that what makes transsexual women such as herself different from other transgender people is that she believes gender is binary, not that it's on a spectrum. "As far as we're concerned, we're females," she says. "We were always born females. We were just born in the wrong body."

"There is a very big anti-separatist movement going on, but it's the transgender people, who tell us we're under the transgender umbrella, whether we like it or not. And without trying to get into that politics, the point is that we are actually different, because they believe in the spectrum and we believe in the binary."

Health Minister Tony Ryall has recently replied to a request under the Official Information Act from McGonigal, in which she asked about funding and waiting times for gender reassignment surgery. He has transferred the request to the Ministry of Health.

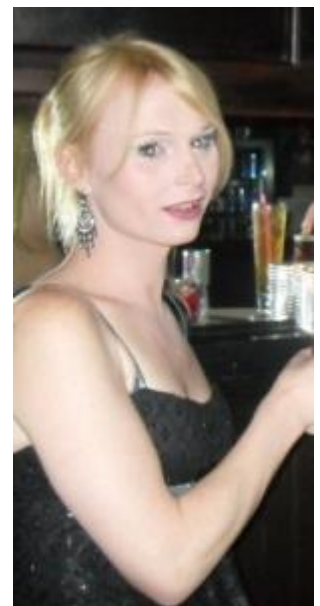
So, politics and politicians aside for now, we come to **Jasmine Eastall**, a 28-year-old pre-op transsexual woman who says she is considering not even bothering trying to get on the waiting list for gender reassignment surgery, because it's ridiculously long.

"Technically I could just get any odd job out there and save 25 bucks a week, and get the surgery myself through Thailand."

Yet she feels like it's something the Government should pay for, and she should have realistic access to.

"It's hard to explain but, you wake up every day and, it's not something that you just think about on an occasion or monthly, or when something happens. It's something you constantly think about, every time you shower, every time you go to the bathroom, every time you change, even every time you're walking down the street and feel uncomfortable," she explains.

"It's when you see other women, it's when you come across relationships and try to meet someone you really like, it can be really daunting sometimes. As Simone was saying, it is a deformity to us. It's something that we don't want to be there. We feel it's not our fault that it was there at birth. It's like an accident. Like any accident really. Mother Nature makes mistakes too."



Jasmine Eastall



Jacqui Stanford - 1st June 2012

Appendix F. Examples of Possible Trans Suicides ignored by Healthcare Planners in NZ and Australia

My own friend - 3 years ago - male aged 60 years

He suicided with 1 day of slight warning. As he was generally one of the most stable people I knew, I thought it was inconceivable that he might suicide. Of all of my friends, he was the one who made the fewest mistakes! So I was astonished when his suicide unfolded. He showed himself no mercy, using helium gas to asphyxiate.

When I faced my own transsexuality, I learned much more about these issues. I was then able to see the same signs in my now dead friend. This markedly increased my motivation to get treatment, as I could see no alternative but to face this difficulty head on, rather than keep trying to bury it.

He told me “don’t trust doctors” and gave me several examples from other people, as to why. “Trust them as far as you can throw them!”.

When I heard about ADHB refusal to fund GRS, yet such funding is automatic in almost all European states, I smelled a rat and generous cockroaches. This led me to check the health economic calculations for myself. This report is the result of that work. It seems hard to credit, that even seeing the disparity between NZ and Europe, that ADHB choose not to check the quality and equity of their decisions in trans healthcare?

Accordingly, this report is dedicated to his memory and to protecting trans from ADHB’s iniquitous and very poorly thought through decisions. This appears to reflect the prejudices that they bring to their job.

Maybe my calculations have errors in them. Even so, I don’t believe that these could be large enough to alter the conclusions. That is what really matters.

The Impact of 15 year old girls Adolescent Suicide A clinical story by Prof Martin Graham

(read about suicide in submission to Australian Senate enquiry into Suicide in Australia)

sub107a Martin Graham, Professor. Graham

This document was found on the Australia Senate website, about 2009. It might no longer be available on internet??

The experience which led to my involvement in Suicide Prevention as a passionate career choice within Child and Adolescent Psychiatry, was a 15 year old girl who forged her mother's signature on a request to go to the Orthodontist, left her private girls' school, travelled into Adelaide by bus, and jumped from the 9th floor car park of John Martin's Store on North Terrace. I subsequently came to work with the family - in part to explore the history further, but also to provide grief work support for well over a year.

Christina's mother died from a heart attack ('? A broken heart') some 18 months later; she just could not come to terms with her daughter's death. The older sister (the only surviving child) herself completed suicide about 3 years later, overwhelmed by the loss of her sister and mother. The father developed hypertension and died of renal failure 10 years later. They all suffered immensely emotionally, and just could not understand the death of a perfect daughter.

When Christina landed on the pavement of North Terrace, she was within 10 feet of a young male nurse. He did what he could, handed over to the Ambulance people, and went on his way to work. By chance he was a friend of my younger son (Adelaide is a small place), and 3 months later on a visit to my home he began with "You knew that girl who killed herself...?" and broke down and cried for the next 3 hours. He needed ongoing care for several months, and when we meet occasionally now he still recalls aspects of the trauma. An accidental bystander – like the 10 or so others I never met.

Two years later, I presented to a Rotary Club meeting one night (one of many), and told the story to engage the audience in the problem of suicide. After the meeting, the Ex-manager of John Martin's bailed me up for some time to tell his story, and weep. He had never sought care or support, but Christina's death was in many ways the last straw before leaving the job.

In Christina's school we set up a process of grief work with 30 teachers. Several teachers were distraught, had taken time off school, and raised issues of their competence to look after young women. The class teacher was very traumatised, and raised one question that was very hard to consider: "What do I do with the desk?" The consensus was that she should ask the girls from the class; the desk was left for the next month, and then moved to the back of the class for the end of term. Every day a fresh flower was placed on the desk.

The work with the girls entailed 30 young women with whom we spent over 2 hours, who then completed questionnaires. Through this, the results from the scales, and from other discussion, we found out that 2 girls had attempted suicide one the day after, and one within the week after Christina's death ("If she can succeed, then I need to give it another go..."), at least 8 more deserved formal assessment, and 4 were placed in therapy.

This description of events is not unusual. Various estimates of the ripple effect out from a suicide have suggested it might be 6-10 people who are badly affected, including family members. My personal experience is that this is a gross underestimate, and the costs from inability to work are hidden and not accounted for in calculations that exist.

Members of the Senate Inquiry, you will hear a wide range of estimates of the cost (perhaps somewhere around \$250,000 per suicide), but the personal and social costs over time are immeasurable. Every thing we can do to reduce the numbers in Australia reduces the pain, reduces the exposure, reduces the copycat behaviour,

reduces the inner sense in all of our minds (and the pervasive belief in our society) that suicide is always an option.

Christina's case raises another issue that is rarely considered. She was never abused, came from a caring middle class family, was a straight A student, played second violin in the orchestra, and played in the school soccer team. She was well liked by staff and students, and despite an intense search through her writings to find some clue, one was never found. The dilemma is How do you prevent this kind of not so rare suicide?

There is no Early Intervention, we never get to analyse risks or get a risk form completed, we never get the opportunity to prevent – except afterward. To my mind this raises some fundamental issues about our society, how we parent, how we instil Resilience and Optimism in young people, how we keep them connected to family, friends and groups and clubs. You will hear lots about the Pathways to Suicide, about suicide in those with mental illness, or from special groups, and this may be about services, professional skill, the use of psychotherapy and medication.

On the other hand, we will only stop the Christinas of our world by Universal programs in our communities, schools and families, through Mental Wellness Promotion, by developing a sane sensible and caring Australian society. If that sounds too broad or too loosely construed so be it.

Christina's death led my team (then at Flinders University) to devise school-based programs. First, we did 17 cross sectional studies that built to a large-scale 3-year longitudinal study of risk in young people. We said to ourselves: "If we can discover so many troubled and suicidal people after a suicide, why can't we find them before someone dies?" I won't bore the Committee with all the studies, but a list of papers appears in the publication list.

Building programs in Schools (Queensland)

I PUT THESE PROGRAMS AT THIS POINT BECAUSE THERE IS NOT A CATEGORY IN WHICH TO PLACE THEM IN THE SENATE ENQUIRY, YET THEY ARE AN OUTCOME FROM THE SUICIDE OF THE FIRST OF MANY ADOLESCENTS I HAVE EXPERIENCED.

The interest in school-based prevention continues to the present day, but we have devised a rather nice program that is not about education around suicide; it is *'the program you use to prevent suicide when no-one actually mentions the word'*.

Rather it is about building strengths, optimism, connectedness, and social skill. A key part of this is a program on Pathways to Care for those young people who show up as particularly disturbed and in need of further help.

The process is 20 weeks (2 terms) of an internationally acceptable program based on 'Aussie Optimism' from Dr. Clare Roberts at Curtin University. We don't just provide the training to teachers to run the program, set it all up and move on. We do pre- and post-testing, and compare the results. Then we sit down with year coordinators and senior staff in the school, and work out in school

programs for those who need the help, and for those we are really concerned about, we engineer referral to local child and youth service. We have found it hard to gain funds despite the successes of the program, so we are operating mostly in schools prepared to pay on a 'user-pays' basis.

A recent paper from our group (which accompanies this submission):

Swannell, S., Hand, M. & Martin, M., 2009. The Effects of a Universal Mental Health Promotion Programme on Depressive Symptoms and Other Difficulties in Year Eight High School Students in Queensland, Australia. School Mental Health,

Building programs in Aboriginal Schools (Queensland)

We are in the process of developing a version of this program for Aboriginal young Australians. Two PHD students (one an Aboriginal Australian) have been engaged to use funding provided by Queensland Health to create the program (based on Aussie Optimism). We are one year into development with 2 more years to go, and are currently working with 3 schools in Queensland who are helping us to get the approach right.

On the face of it, this is not directly a suicide prevention program, but it is precisely that - taking a long-term view. It is a long-term outcome from Christina's death.

Student killed herself after buying lethal injection drug

<http://www.telegraph.co.uk/news/uknews/9898476/Student-killed-herself-after-buying-lethal-injection-drug.html>

A gifted A-level student killed herself after being able to buy online a drug used for lethal injections on death row in the United States, an inquest heard.



Isobel Narayan, 16, pictured with her dog Bracken, had 'unfathomable' low self-esteem Photo: Cavendish Press



By **Nick Britten**

6:17PM GMT 27 Feb 2013

A coroner called for tighter controls on selling lethal drugs over the internet after hearing that Isobel Narayan, 16, came across the substance having searched online forums about suicide.

Nigel Meadows said he would be writing to the Chief Pharmaceutical officer to see if anything could be done to tighten regulations about access to harmful drugs.

He said policing the internet was "virtually impossible" but it was a "matter of public concern" that Isobel was able to get hold of the drug.

Isobel, the daughter of a barrister, was found dead by her parents at their home in Didsbury, Manchester, in December 2011.

An inquest heard that there was nothing to suggest she was unhappy but a police interrogation of her computer revealed she suffered "misplaced" and "unfathomable" feelings of low self-esteem and worthlessness.

She had ordered a drug online and in the months before her death had looked up forums giving guidance on assisted suicide for people with terminal illnesses, Manchester Coroner's Court heard.

Isobel wrote a document entitled: "Reasons why I should kill myself or why my life is not worth living", the hearing was told.

Her father, Harry Narayan, a barrister and crown court recorder in Manchester, told the inquest his youngest daughter, who had gained top marks at GCSE, was top of her year in physics and studying A-levels with the hope of studying to be a vet like her older sister, Freya.

A keen horse-rider she was also on the student council at Xaverian College in Manchester but was "so able", her studies did not really challenge her and she craved more homework to do.

There had been a "mini crisis of confidence" the month before she died, he said, but Bell, as he called her, returned to college a week later and got back into the rhythm of student life with everything appearing normal. He said on the night before the tragedy Freya had gone out and he had waited up for her.

He said: "I stayed up waiting for Freya to come back in the early hours of the morning. At 1am, I heard Bell cleaning her teeth in the downstairs bathroom. I said, 'Are you all right'? Everything was normal."

The inquest heard that around noon, Mrs Narayan went upstairs to rouse Isobel to see if she wanted a bacon brunch.

Mr Narayan added: "Anne went to ask her about a bacon butty and came back down and asked if I could go and see her. She was dead."

The parents raced up to her room where Isobel was lying on the top bunk of her bed, which has a desk underneath.

He added: "She was lying in her usual sleeping position right arm over her head. I felt her forehead and it was cold.

"I remember everything vividly. She had a bucket which I use when I clean the house, there was a bit of liquid in it. There was a Listerine bottle on her top bunk and there was a tumbler on the window sill that had some dried powder on it.

"She must've got the bucket some time after I heard her at 1am", she said.

Mr Narayan said he had spoken to his daughter about boys, pregnancy and bullying, but there was nothing in her life to suggest she was unhappy or worried.

Det Insp Kevin Marriott, from Greater Manchester Police (GMP) who investigated the death, said searches of her computer found she had made inquiries about obtaining the drug and around a month before her death a quantity was posted to her in two packages.

The hearing was told that Isobel had gone on forums and discussed "the use of the drugs and quantities and dosages and uses and guidance and sources of advice for those people wishing to harm themselves".

There was also a pamphlet available online designed for those with terminal illnesses who want to end their lives.

Det Insp Marriott said that while Isobel had low esteem, the "self-deprecating comments" she made in the document "Reasons why I should kill myself" were "totally misplaced". He added: "It's unfathomable."

Ruling that the teenager killed herself, Mr Meadows, the Manchester coroner, said: "There were no indications that she was even contemplating taking her own life. There's no clue or indication that anything was untoward whatsoever."

He said it was "inevitable" in such cases loved ones will ask themselves if they could have noticed something wrong, but said there was nothing Isobel's family should reproach themselves for.

He said: "It's a strange time of life for teenagers. There's hormones raging, there's pressures."

Human Rights Complaint 034 to UN

41 year old farmer circa 1910 in NZ (older relative of my school friend)

About 1910, the man's 15 year old son found his father bleeding to death, from a self inflicted cut throat. The father would have been unable to speak, just able to make gurgling noises as he died in his son's arms.

The family had moved some distance to their current home some 18 months earlier, to a new job. The whole family had moved together. Although finances were barely comfortable, there was no sign of particular financial or social problems. There had been no indication to the family or neighbours of the tragedy about to unfold.

A few months later, the son who found his father, disappeared. He was unable to be traced by family, even with extensive efforts. nearly 60 years later he returned to the family and it was found that he had taken off to Australia, as had been suspected. Although he was ok, his life had been severely impacted and he had barely survived what he had witnessed.